MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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9:11 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
PETER KEMPER, Ph.D.
JUDITH R. LAVE, Ph.D.
DONALD T. LEWERS, M.D.
HUGH W. LONG, Ph.D.
FLOYD D. LOOP, M.D.
WILLIAM A. MacBAIN
WOODROW A. MYERS, JR., M.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
GERALD M. SHEA
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

DR. WILENSKY: Let's get started. Gentlemen?

MR. ZABINSKI: Today, Scott and I are going to talk about our preliminary findings on geographic variation in per capita fee-for-service spending and propose a new way of looking at payment patterns.

There is substantial variation in Medicare+Choice payment rates across geographic areas. This is due, in part, to the variation in counties' 1997 fee-for-service per capita spending because blended payments depend on the per capita spending which has substantial variability. The variation in fee-for-service per capita spending has three primary components, health status differences, input price differences, and practice pattern differences where practice pattern differences include differences in the ways doctors make decisions about service use as well as beneficiaries' inclination to use services.

What we wanted to do was break the variation in fee-for-service per capita spending into its three components to get a sense of the relative importance of

each, especially in regard to the practice patterns. To do so we started with HCFA data on 1997 fee-for-service per capita spending for each county. And then we adjusted those values with the intention of removing the effects of differences in health status using risk scores from the interim risk adjustment system to measure health status.

Then we divided those results by the counties input price indexes to remove the effects of differences in input prices. Ideally, the final values that we had would reflect only the differences in practice patterns. However, the risk scores from the interim system don't fully account for the differences in health status. So those final values actually are some combination of the practice pattern differences and some of the differences in health status.

Our preliminary results show that after adjusting the 1997 fee-for-service per capita spending for health status and input prices, substantial variation remained. Our findings are comparable to those for the Center for Evaluative Clinical Sciences at Dartmouth Medical School and imply that much of the variation in per capita spending is

due to practice pattern differences.

However, these results should be interpreted carefully and considered only a first approximation because they likely overstate the true variation that is due to practice patterns and they're probably a combination of the practice pattern variation and the variation in health status.

Because we have found a large variation that likely overstates the true variation, we intend to do an additional analysis for the 2001 production cycle using a better measure of health status, that being risk scores from a yet to be determined comprehensive risk adjustment system.

Whether to continue to allow Medicare+Choice payments to reflect the variation in practice patterns raises some important policy concerns. One is whether higher payments in the counties with relatively costly practice patterns result in better health outcomes relative to the outcomes that would occur in the absence of the higher payments. If this is true, this raises an equity concern, that being should not all Medicare+Choice enrollees

have access to the more effective care?

But if the higher payments are not associated with better health outcomes, then the organizations in the counties with the relatively costly practice patterns have more flexibility in terms of substituting benefits such as prescription medicines for the costly treatment methods used in the traditional program.

This raises two more equity issues. One is whether it is appropriate for Medicare+Choice beneficiaries in the counties with relatively costly practice patterns to receive substantially more benefits than others. Some might argue that they should not and therefore payments should not include the effects of practice pattern differences.

However, this leads to the second issue, that being if the effects of practice patterns differences are removed from payments, could Medicare+Choice plans compete with fee-for-service in the counties with relatively costly practice patterns?

That's all I have today and now I'd like to turn things over to Scott.

MR. HARRISON: Dan has raised some interesting distributional issues, but rest assured I do not intend to solve them in the next few minutes. Instead, I'd like to discuss how we look at the notion of cost in the Medicare+Choice program. A shift in thinking about the costs may provide us with more tools to use in addressing those distributional issues and in making recommendations on Medicare+Choice payments.

The Medicare costs of the Medicare+Choice program are usually seen in terms of the fee-for-service cost that the traditional Medicare program would have incurred if the enrollee had been in a traditional program. Some examples of how this thinking gets into the process is the blended rates are based on historical fee-for-service spending, the annual update is tied to increases in fee-for-service spending and the Medicare program. The risk adjuster systems are all based on fee-for-service spending patterns. And government agency auditors, they use fee-for-service billing practice guidelines when evaluating the Medicare+Choice cost submissions.

The problem with approaching Medicare+Choice costs in this manner is that the plans may have cost functions that are very different from the traditional Medicare program, and their actions are difficult to understand when you look through a fee-for-service filter.

Returning to our distributional issues for a minute, in the BBA Congress did state that it wanted Medicare+Choice plans to be available as a choice for beneficiaries. In order to understand the patterns of plan availability, we would need to understand what influences plan location decisions and cost is no doubt a major influence.

The next slide illustrates a very simple model of plan costs that seems compatible with our current understanding of plan location decisions.

There are three primary assumptions underlying this. There are fixed administrative costs represented here by A, to participating in the Medicare+Choice programs that are independent of the level of medical spending by the plan.

Two, the plans are able, through their administrative investment, to either pay providers lower rates or to improve the efficiency of their providers' practice patterns in order to deliver medical services at a lower cost than the traditional Medicare program.

And three, at some level of fee-for-service spending, the costs of the two delivery systems would intersect.

This model could explain why plans are more available in areas with high fee-for-service spending, meaning high payment rates, so at the right-hand side you've got Medicare+Choice plan costs well below the fee-for-service costs, therefore it could explain why plans in high payment areas can afford to offer richer benefit packages than traditional Medicare. Yet on the left side, they're not able to survive in markets where there is low fee-for-service spending or low payment rates.

This model could be consistent with both the claims of GAO that plans are overpaid on average, and the claims that plans are underpaid in many markets. This model

could also be useful in predicting the effects of different payment proposals, such as raising or lowering the floor or changing the minimum update percentage.

A well-specified model may help us face some of the distributional issues by enabling a broadening of the geographic area where budget neutrality is required, and it may be able to help us calculate budget neutrality on a wider area.

Congress began that type of approach through the blended rates included in the BBA, and this type of model might help us analyze and make recommendations on the blend percentage and the blend approach in general.

At this point, however, the model is completely unspecified. We don't know the value of A. We don't know the slope of the line. We really don't even know that there is a line there. So we plan to estimate the model using cost data that the plans have submitted to HCFA, the so-called ACR data.

Beginning this year, plans were supposed to submit base year Medicare+Choice data. Their cost data base year

is 1998. This data is now available. In prior years this data didn't exist because the plans only submitted projections.

In the future, then we would like to take this model, if one develops, and link that with an enrollment model that would predict enrollment based on Medicare+Choice payment rates to sort of get the whole set of possibilities, what would happen with changing rates.

Now I'd like to hear your feedback.

MR. MacBAIN: Dan, I have a number of questions for you. Maybe the easiest thing is let me run through them and then you can go through it.

One is how do you treat DSH? Is that an input price or not? And if you're of the epiphany persuasion, how do you include GME?

Second is treatment of beneficiaries who are not taking advantage of benefits, DOD and VA beneficiaries.

Third is are there other variables that could have impact on this, such as a prison population in a rural county, state hospitals? Is there any way to measure the

impact of low Part A and Part B enrollment in a given county, again particularly in rural counties where you're dealing with a small denominator to begin with?

Based on some of the information from the last meeting, that indicated that perhaps the high percentage of people joining Medicare+Choice plans are receiving incomes below $25,000 and do not have Medicare supplemental benefits, which would make them a fairly unique population compared to the broader number that goes into the AAPCC. Is there a way of comparing their per capita costs to the AAPCC, to get a sense of whether when you're done you're really measuring the variables in the population that's enrolling in the +Choice plans?

MR. ZABINSKI: Can we go through those one at a time?

MR. MacBAIN: Let me have one more and this may be the toughest. Again, thinking of rural counties, back in the old AAPCC days, the year-to-year variation was one of the real difficulties in trying to sustain a rural plan. You're going to be looking, I think, at just a one year, the

base year. Is there a way to average that? Take say '95, '96, '97 and average them so that you do away with some of that year-to-year noise?

MR. ZABINSKI: Let's see, that last one, as far as data availability, I'm not sure if we could handle it that way. The data that we have is straight from HCFA website and we wanted to go back to the 1997 levels because that's where the actual per capita spending in its purest form is.

But as far as looking at a number of years, it's just something I'd have to look into.

MR. MacBAIN: If nothing else, you may want to at least want to address the extent to which that would or would not improve the analysis. My main concern is with the small counties, where there's been so much variation year-to-year. But if you pick a low year for one county or a high year for another county, it may not be representative of what you're actually trying to measure.

MR. ZABINSKI: I hadn't thought about that but I think it's a good point. First question.

MR. MacBAIN: The special input prices, primarily

DSH but possibly also medical education.

MR. ZABINSKI: I hope this can answer your question. I will give you the general outline of the method. We adjusted the Part A using hospital wage index, sort of in the similar fashion of how rates are adjusted, specified under the BBA. It's sort of .7 times the hospital wage index plus .3. And then you use that as a divisor. You just divide the rate by that result.

For Part B it's a little more complicated. You use the geographic adjustment factor and the hospital wage index together.

MR. MacBAIN: So to the extent the DSH and GME payments are included in the figure you're adjusting, that's going to be treated as -- well, it wouldn't be a difference in input prices, so it's part of the residual. So it's essentially a practice pattern issue, if you happen to have a lot of teaching hospitals or hospitals that quality for DSH.

MR. ZABINSKI: Okay.

MR. MacBAIN: The second one was what happens in

the denominator when you've got people who aren't using benefits but are counted as beneficiaries, such as DOD, VA, and possibly -- I don't know whether prison populations or state hospitals would be lumped into that.

MR. ZABINSKI: I'm sorry, I'm not quite fully understanding the question.

MR. MacBAIN: Again, you've got a rural county where half the Medicare beneficiaries qualify for Veterans Administration benefits and drive into the nearby city to get services from a VA hospital. They count in the denominator when you're calculating the per capita cost, but they're not generating per capita costs at nearly the same rate as other beneficiaries.

You're going to measure that right now as a practice pattern differential when, in fact, it's a denominator problem. Either that or find some way of incorporating the costs in the numerator.

MR. ZABINSKI: Right. Quickly thinking about it, I don't think that the method that I used allows for that distinction.

MR. MacBAIN: My concern is that you've got three components but there are some other variables in there that you can't just assume the practice patterns is the residual and control for input price and health status.

MR. ZABINSKI: As far as I can tell, the method that I used doesn't allow for that adjustment, but I think it's something to think about.

MR. MacBAIN: I look forward to more complication in the next presentation.

MR. ZABINSKI: Empirical work, it always seems like there's more complications coming up all the time.

MR. MacBAIN: The last one was just a comment about whether you can get access to data that would let you compare the low income, non-Medicare supplemental population with the overall AAPCC.

DR. KEMPER: I just want to start by saying I found this very thought provoking so I'll make a number of comments. One is I'm not sure where this is headed in terms of the distributional issues, but you raise the question pretty explicitly of who gets the savings if the HMO care is

lower.

And I think, in thinking about that, we need to remember that beneficiaries are trading off more benefits for less choice in a different kind of care delivery. So if you just look at the cost, you're missing the consumer aspect of that choice. And at least in the commercial sector, there's some notion that employees are trading off some lower out-of-pocket costs for less choice and a different delivery style.

So just focusing on the cost and saying well, Medicare ought to take all the savings, is something we ought to be wary of. It's also the case that, to the extent that you might want to have incentives to move people into managed care, you want to think about taking away that incentive.

Secondly, I had one question about what you mean by looking at costs because the benefits differ depending on what's offered to the beneficiaries. And presumably that's related to the competitiveness of the market. So it seems to me there needs to be some sort of actuarial

standardization of the benefit package when you're looking across counties or across markets, because the policies aren't the same.

MR. HARRISON: The ACR data separates the Medicare benefit package specifically from the other types of benefits that are offered, the supplemental and the additional benefits.

DR. KEMPER: And which would you be looking at?

MR. HARRISON: We would be looking at the basic benefit package.

DR. KEMPER: But I think with respect to this consumer choice issue, you might also want to have at least part of the analysis look at what's happening to the consumer benefits.

The third thing is that -- and it's along the theme that Bill was talking about, and I thought the model was useful as heuristic model of saying the cost functions might be different. But one thing to think about is the geography and economies of density in rural areas, because I'm not sure that's an administrative cost or management

cost economy of scale issue, but more an economy of density. It's hard to put together a network, and so on.

And I guess the last thing is the health status measure has its limitations and whether you could look at multiple years of data in your file to get a better measure of health status by looking at diagnoses over several years to improve that.

But I found this very thought provoking.

DR. LONG: I agree with Peter that this has stimulated a lot of thought and I like the idea of proceeding to see if we can produce a model. I'm sorry that Alice and Janet aren't here to test some of my recollections about things, but I would emphasize Bill's point about the year-to-year variation. That's not just a rural phenomenon. If I remember correctly from AAPCC tracking over many years, there was huge year-to-year variation. Which is why a five year moving average was incorporated in some of that original rate setting methodology.

And certainly in a couple of MSAs that I'm familiar with, there's huge variation between adjacent

counties, even though the face demographics look very much the same.

I would also reiterate the potential influence in lower population areas of the VA, DOD interactions.

A technical question on the ACR. Doesn't that include sort of a straight line cut at the fixed costs, the A mirroring the commercial side of the business?

MR. HARRISON: I suspect it does. It's going to be cost accounting and how they actually have it.

DR. LONG: So you need to be careful with that piece of it. The other stuff is actuarially determined, as I appreciate it, but the administrative part is a cost accounting potential artifact.

And then finally, I would think that, again from just personal experience and observation but here's where I wish I had Alice and Janet, it would seem to me that a major variable here is the extent to which there is risk plan or Medicare+Choice penetration in the county because your fee-for-service number is the residual of all the people who didn't sign up for the program. And as you see all those

neat ads with the tennis playing, back-packing seniors, and you figure out who at least initially was in these plans, one would expect there to be a very positive correlation between, at least in the early stages of enrollment, between the enrollment and the remaining per capita costs in the fee-for-service sector.

DR. WILENSKY: Although we've never actually seen that.

MR. HARRISON: There was some research a few years ago that talked about a managed care spillover. I think it was a guy named Baker from Stanford actually found that the higher the Medicare penetration, the lower the spending.

DR. LAVE: No, the overall penetration.

DR. NEWHOUSE: Both have been found. You're right about Baker, but there's another finding on Medicare specifically.

DR. WILENSKY: This is something Lou Rossiter raised 10 or 15 years ago in some stuff that he was doing, that he would expect to see higher fee-for-service as a residual if, in fact, there was this kind of selection. But

both the Lawrence Baker studies and other studies have actually never shown it. If they've shown anything, it's the reverse.

DR. NEWHOUSE: But also on that point, I had a doctoral student who did find the higher rates from the selection phenomenon also.

DR. LAVE: That's the one I remember, too. There's been studies finding both ways, that overall penetration is clear. I'll make some comments later on this.

DR. NEWHOUSE: I have comments at several levels. Along with Bill's list, with the GME and the DSH, you could toss in Medigap variation which will influence fee-for-service variation.

I have some higher level concerns, though. You agree that the residual variation is greater than the practice pattern variation, but then when you go on to interpret this, in terms of what to do about policy, you asked do higher payments lead to better outcomes.

Well, to the degree there's residual health status

variation in there, which there surely is and will be even after you get the HCCs in there, I would say, then there needn't be better outcomes. You could just be picking up the residual variation in health status.

If higher use areas are also sicker areas, you'll measure that. I would be more worried about that if I thought you could actually measure outcomes, but I don't think you can really measure outcomes very well anyway.

So I'm not sure where that leaves me with this.

In terms of the stuff Scott presented, I thought that was kind of an interesting conceptualization and let me push you one step further, in terms of policy implications. It seems to me the policy implication would be that, at least for managed care organizations above a certain size, one would ideally pay a lump sum that would cover the fixed costs and lower the rate per person to the marginal cost rate.

MR. HARRISON: That's a possibility, I guess.

DR. NEWHOUSE: That seems to me what follows from this.

MR. MacBAIN: It sounds like partial capitation.

DR. NEWHOUSE: No, it wouldn't be partial capitation.

MR. MacBAIN: You're talking about fixed fee, just flat.

DR. NEWHOUSE: Fixed fee plus, yes. Yes, that's what I'm talking about. It seems to me that's what, if you're fitting this cost function, that's where you go.

DR. KEMPER: But we don't do that for hospitals.

DR. NEWHOUSE: That's right, which also --

DR. WILENSKY: Presumably, if you were going to do this, this is what you would do for many other plans.

DR. KEMPER: But those are markets along the axis. Those weren't number of people.

DR. NEWHOUSE: But if you extend this kind of reasoning, you say that for the administrative cost, the HMO is managing to treat each patient at a lower cost. Presumably they're out there negotiating discounts or they're managing utilization in some fashion.

MR. MacBAIN: I think Scott's point is that the

production function is different. It's not necessarily a pure fixed and variable. The HMO variable cost, it may have a number of variable costs that go up more slowly for various reasons, that would affect the slope of the line, other than provision of health care services, marketing costs or something. I don't think you know.

But the point, I think, is a very good one, that the production function is different and it's different enough that it's going to have an impact on how plans evaluate rates.

DR. LEWERS: I'll be brief because I think the points that have been made are ones that I wanted to make, perhaps in a little different fashion.

Dan, in the point that was brought up about the vets program, the military, et cetera, you might take a look at Ohio. Floyd might want to comment on this. Ohio, in their county basis, if you take a look at that, it will very quickly demonstrate to you the differences that occur where there is a military base. I'm sure there are other states, I just happen to be familiar with what has happened in Ohio.

I think the point that was just made in that discussion is one that I wanted. When I look at you table with costs and the cost differences on either end compared to fee-for-service, I think we are perhaps isolating out the managed care program as having certain costs that the rest do not have. I think you can argue that.

Those costs are there, they're in a different framework. I think what Peter is talking about with hospitals, I can also argue the same thing with physicians, cost of starting practices, a number of issues, the startup costs. And they are marketing that. So I don't necessarily agree with that, but they are.

And so I just think that you need to take all of that into consideration when you're talking about the base on what you're really dealing with at this point in time.

So I don't know that there's a lot of difference. The costs are different, the costs are labeled different. We look at them differently. But they're the same, if you really want to argue it.

And that's the point I think Joe is talking about

with the differences in the various studies that have demonstrated that. I think that's the same area, a little different context, but I think it's the same. So I don't know how you're going to look at that.

DR. ROWE: A couple points. One is that I am assuming that age is one of the health status measures; is that right? Is age in there? Because the slope of the relationship between expenditures and age is very steep and relatively minor differences in age from different counties because of people who are retiring or whatever, will make a big difference.

MR. ZABINSKI: Age is part of the interim risk adjustment system. It's a factor that's used in it.

DR. ROWE: Secondly, are there measures of socioeconomic status? Bill commented on this, I think that may be an important determinant of the process of care. People have an informal support system, they require less formal supports than people who don't have an informal support system. It's part of the variation in care which is not physician determined but is more patient determined.

There are racial and ethnic and other characteristics that go into this. We know that people with the same disease have much different illnesses based on their socioeconomic status. Is that in there?

You should look and if it isn't, you might consider producing a variable, if you have one, that relates to socioeconomic status.

The third question has to do with the utility of the findings when we're done. As I understand from what you said basically these are not 1997 data. This is the average per capita expenditure in these regions from 1991 to 1995, so let's call it 1993 on average. Then trended forward according to the national 1997 expenditures.

So whatever the average increase or the total increase from '93 to '97 was for the country, that's how you trend for these individual expenditures in these individual regions. So we're talking about 1991 to 1995.

And I would submit that the pattern of care in many hospitals with respect to the length of stay, with respect to the variation and the treatment of individuals

with the same DRG with practice plans and all the things that we talk about all the time has changed very substantially in the last seven years.

So I'm therefore concerned that people are going to deeply discount the findings by saying that was then but this is now and it may not be that relevant, or whatever. So I'd be interested in your response to that, that may not be valid. But I'm concerned about the fact that things are changing pretty quickly out there and we're really talking about seven-year-old data.

The last thing, and we've gotten a lot of economists and people here. I'm not an economist, in fact I never even took economics, which is probably self-evident. And when I did research, it was in a laboratory. So this is college statistics that I'm relying on here from many years.

What you're doing is you're using the coefficient of variation, which is the standard deviation divided by the mean, to develop an increasingly kurtotic distribution as you refine out some of these characteristics that determine some of the coefficient variation.

I wonder why you don't do something like an analysis of variance, where you can define the amount of variance rather than variation which is attributable to various characteristics, which might not be exactly the same as relying on the coefficient of variation.

That may be wrong, but that's sort of a distant memory.

MR. SHEA: You're worse than the economists.

DR. ROWE: This is statistics 202.

DR. LONG: Do you want to give a lay definition of kurtosis?

DR. ROWE: A kurtotic distribution is one that is increasingly steep, isn't it? And constrained, with a smaller coefficient of variation.

DR. NEWHOUSE: It has to do with the thickness of the tails.

DR. ROWE: So somebody around here can correct me on that, but I'm most interested in your concern about your response to the seven-year-old nature and the changing baseline of process of care.

MR. ZABINSKI: I think that's something to think about.

DR. ROWE: That's fair. I'll accept that.

MR. ZABINSKI: I don't have some grand comment to give you right now.

MR. HARRISON: Jack, do you think the variation would have changed?

DR. ROWE: Yes, I think that exactly the variation would have changed. I think that the way we design these programs is I look at the variation, and Dr. Loop I'm sure looks at the variation at his hospital, and say we want to decrease this variation. We want to improve the effectiveness and the efficiency and the predictability of the care of a patient with a hip fracture and remove the very long lengths of stay and the complications that cause those, whether it's delirium or infection or whatever.

So by putting the patients in care plans where we more carefully monitor the resources and the status of the patient, our goal is not just to reduce the length of stay but in fact, my goal is to reduce the variation. It's

another way of also, I think, reducing error.

So that's the point. And therefore, I would think that the variation would have decreased over the last seven years, yes.

DR. LAVE: I must say Jack has taken me kind of aback because I had not realized we were not dealing with 1997 data but were dealing -- is he right, that we're dealing with basically 1993 data?

DR. ROWE: On the top of page four it says, it is important to note that a county's 1997 per capita spending is determined by multiplying the national '97 spending by the relative value of the county's spending from 1991 through 1995.

DR. NEWHOUSE: That's the five-year average lag.

DR. ROWE: Yes, so it's 1993 trended forward to 1997. So it's just that much older.

DR. LAVE: I guess my problem is I'm not terribly sure why we're doing this, the more that I think about this. I sort of have two reactions. One reaction is can we develop a better model to explain the per capita variation?

I think that there have been a number of suggestions here that have said that we can do that.

I have some that I think that Bill put us on the right thing. You want to take out the DSH and I would say you want to put in Medicaid because mostly Medicaid people are in the fee-for-service sector. And we know that they're relatively high use.

I would want to put in the Medicare penetration of plans but it's sort of difficult if it's five years trended forward.

But I think we could all develop a better model and my assumption on the model is that I would try to model it very well and not necessarily tie it to Medicare payment policy if I could do a better risk adjustment. There was some interesting work by Cutler, who did this.

But then I guess the question really comes, what do we have when we've ended up there? What does it really tell us about how we want to go about paying plans? I'm not sure what it really tells us about how we want to go around paying plans.

It has always seemed to me that I've always been sort of puzzled about what to make about the variation in expenditures in a fee-for-service world, in a policy framework, because people get their care in the county in which they get their care. So it doesn't seem to me there's some way of saying okay, Judy, you're unlucky enough to live in Massachusetts but I'm only going to give you enough money to buy the kind of care you could get if you lived in California and good luck to you. I just don't know what that means.

The question about how we should pay plans, it strikes me, is where we ought to be focusing our attention, and whether or not it makes sense to focus how we pay plans on the current administrative pricing system. Is that the right way to go? If we do that, then how should we really set that price? And how should we tie it to what's happening in the fee-for-service world? Or should we? Because we know there are these peculiar balances.

Or should we be moving towards more of a one where you have the plans come in and negotiate and bid over the

amount that they want to charge us to take care of these patients?

So I think that our work -- I guess that I come out to think that it's probably more important to try to figure out really the strategy we ought to be using to paying health care plans to take care of Medicare beneficiaries rather than trying to do some very sophisticated analyses of these very old data as the basis for setting payments for the year 2000, I'm puzzled about.

I think it's intellectually very interesting. I can think of lots of studies and how to go about it, but I guess I really do think that the question we ought to be asking is a different one. The question we should be asking is how should we really be paying plans? To what extent does it make sense to be basing what we pay plans on what's happening in the fee-for-service side? If we were going to really do it, what would we really want to know from the fee-for-service side that, in fact, would make it relevant for setting the payment?

So I keep thinking maybe we want to move ourselves

beyond the box.

DR. WILENSKY: Ted, did you want to say something specifically on her point?

DR. LEWERS: I think she brings up a good point and the complexity of this and the changing structure, because your statement that Medicare is the majority of fee-for-service is a change in structure in itself. I don't know what the numbers are now that are in managed care. I know they're fairly high in Maryland and other states that are doing this.

DR. LAVE: Medicaid and Medicare --

DR. LEWERS: Medicaid patients are moving into managed care because the states are buying the policies in that fashion, so it's another changing parameter.

DR. KEMPER: On Judy's point just quickly. I don't want to put words in your mouth but I thought this was motivated by the plan withdrawal and the payment rates relative to cost. That's really what got you started on this was the plan withdrawal and trying to understand why plans enter one place. Presumably that's a payment cost

issue.

I agree with you, the payment ought to be...

MR. MacBAIN: Let me jump in on this, too. As I understand this, the notion of if you think of a simplified system where you have two counties, one in which the practice patterns are elaborate and one in which they are efficient, the payment rate in the elaborate county would be high enough so that the health plan that can move the practice patterns for its beneficiaries toward the efficient end of the spectrum can make money.

Whereas, in the efficient county, the payment rates are already reflective of that level of efficiency and you can't run a +Choice plan there and make money on it, because the goal has already been achieved.

And in that kind of a system, which is reflected by the current payment strategy -- and Dan's point, I think, is valid that a lot of what determines the county-by-county variation is the practice patterns that are baked into these statistics -- then what we've got really with Medicare+Choice is a program focused on improving efficiency

in those elaborate counties and sort of leaving the efficient counties alone, if you buy that argument, that one of the principal variables in practice patterns.

That's why I think it's worthwhile seeing if there's a way that we can tease that out, to see if we could filter out differences in practice style to see what's left. And if there were a way to gear the county-by-county payment rates based on things other than practice patterns, then you've got a national program rather than a focused program.

Now you know, it's a policy question. Maybe what we really want is a focused program that only deals with these counties that tend to be at the elaborate end of the scale.

I think Jack's comment on whether the data is too old to be valid, for the research question of whether we can determine, whether we can measure the extent to which variations in practice patterns determine the county-by-county variation in the AAPCC, I don't think the age matters that much. It's just a research question of can we find that out.

The difficulty comes then if we want to translate that into a change in how we actually calculate the thing.

I would suspect actually, because most people don't get their care in places like Mount Sinai, that the more that you have been successful in reducing variation, the more you're establishing a different standard from a lot of the rest of the database and the variation county-by-county may actually be increasing rather than decreasing if you're leading the world.

DR. KEMPER: Except it's expanding.

MR. MacBAIN: That's true.

DR. ROWE: I think that's fair. It's just a question of the distinction given limited resources for the Commission and limited time and a very long agenda, to help the staff prioritize amongst all the different things, there are some really useful and interesting questions.

MR. MacBAIN: You talked about statistics and limited resources in the same discussion. You are an economist.

DR. WILENSKY: Let me give you a policy reason. I

think this is actually a very important issue and it has to do with the whole heart of premium support discussions. It doesn't matter whether you support that idea or not, it is clearly an issue that is going to be on the agenda for the next five or six years.

The fundamental principle of premium support has basically been to have a similar payment adjusted for health status and cost of living across the country, although there's a debate about exactly how you want to price out the traditional fee-for-service. But the issues that come up really go the hardest to whether you can sort out practice style variations, and then you can have a debate about whether or not that is something that ought to be regarded, as Peter has suggested, that if people have plan choices, one of the things they may think about as a trade-off is you may go to a plan that has a much more conservative practice style.

You get more benefits but you may get less of something else that other people would regard as important, in terms of either choice of physicians or the style of

practice, in which the physicians practice. Or vice versa, that you stay in a very loosely associated plan where there may or may not be a very aggressively different type of practice style.

Now I don't question the issues or the difficulties that people have raised, as to how you know what you've got, but it would strike me that rather than being an interesting academic exercise, it's something which may not be of critical use for our March or June report in terms of immediate legislative change, although one can say in the year 2000 there is probably nothing that is going to be of immediate legislative change given the particular mood we're seeing develop.

But I actually think this is one of the most important long-term activities comparable to some of the work that PPRC did on risk adjustment in the mid-1990s. And again, we may well, at some point, throw up our hands and say there are problems we just can't resolve. But I think this is just absolutely going to go to the heart of the discussion of how should the government's premium

contribution be made if it were to want to go down this route? And what are the implications of accounting or not accounting for variation in practice style, in terms of the kind of cross-subsidies that exist now and in the future?

So I just think that it's of much higher policy relevance, although again not literally for March or June in 2000.

DR. NEWHOUSE: I'm much more pessimistic. I took this as the motivation for it to be should we narrow geographic differentials? Because if you could take out -- there seemed to be a consensus --

DR. WILENSKY: That too.

DR. NEWHOUSE: You wouldn't narrow -- to the degree it's input prices, to the degree it's health status, you pay for that. To the degree of practice plan variation, you wouldn't. It wasn't clear what that meant for the level of payment, but at least you'd have a debate then about what the level of payment ought to be focused on the variation.

Now the problem with that argument and the reason I'm not nearly as enthusiastic about this is really very

similar to Judy. I don't think you can get -- at the end of the day you won't know how much of what is in the residual is due to unmeasured health status variation. Because all you're going to have, at best, is the HCCs, which we know, in fact, they measure about 9 percent of the variance. And if you just take each person's mean and look at the variance across each person's mean, you should be able to explain at least a quarter of the variance and probably more from time varying things that one would know about and be able to predict.

So this says probably the HCCs, the health status adjusters that will be in here, along with the age and demographics, will only explain about 30 to 40 percent of what you could explain. Now you could potentially correct for that in here and say that well, we'll make that kind of correction and then we'll have left some residual variation that we'll call practice pattern.

But then I don't know where you're at and I don't know that you have a very defensible conclusion.

DR. WILENSKY: Let me just reiterate. To the

extent that we can have any thinking going on about how to try to move this issue forward, this is not something that I see that we need to resolve in the spring or summer of 2000. I just think it's an area in which we ought to try to invest some resources because it is -- I don't know where we're going to go with the premium support debate, but at least at the moment, looking forward to major Medicare reform, it probably represents the area that has the most support.

So at some point this is going to again ramp up into a very serious policy issue. And this has got to be -- I mean, it is, in large part, an issue in trying to set government premiums about this notion of who's problem is the variations in practice style, which we've known for a long time is a significant component of spending. And is it something where basically the government ought to, to the extent it can, say people in areas can decide how they want to do about it? Or is it something they'll say that we'll pay for, which implicitly is what happened under the current Medicare scheme, where we know there are large variations and the government basically finances those large

variations?

I just think trying to see whether or not we can't find ways to assess the residual, either in some markets, or decide once we know where we are whether we want to go out and try to do a special study in two or three areas, where we really try to empirically see whether we can't understand what's in the residual?

As I said, this is not just an interesting, cerebral exercise.

DR. ROWE: It sounds like reasoned and experienced people disagree. I mean, what I'd take away, if I were you, is when you've finished writing the paper, ask the editor to send it to Gail for review and not Joe. These are reasonable differences. I guess it means we should go ahead and see what the results are and you guys will be prepared for the questions.

DR. WILENSKY: I'm not questioning the difficult statistical problems that are there. This is a policy issue that's not going away, so it's a question of whether we can find ways to try to understand the residual better once we

have gotten this step --

DR. ROWE: Is there a way to get fresher data? I mean, can you address that at all.

DR. WILENSKY: It's not the data.

DR. NEWHOUSE: Actually, I think the coefficient variation is that variable over time. I mean, I don't have recent data, but if you go historically, I don't think it's that dramatic a change.

DR. WILENSKY: I don't think that's the problem either. I think the question is what can we find out about the health status differences in some areas, if we were to try it on a smaller scale. That's how I would look at it.

DR. LAVE: I think that I agree with you that your question is a very important question. The question that I have is, how will this analysis inform us about whether or not we can, in fact, do something about premium support?

Now I would begin by arguing that this analysis should not be designed to give us information into setting the premium because it doesn't have the right kind of variables in it. So what we are going to end up doing is

trying to determine whether or not, in fact, we can do a better job in accounting for, at some period of time, the variation and expenditures at the county level.

So that's really what this is doing. And it does tell me that if we can explain this, then we might be able to say well, in 19-X we had this variation and very little bit of this variation was accounted for by whatever health status measure we could find. And so I would say that if we want to try to find -- what is health status and what is variation? Can we get a handle on that at a large level, population base level, not worrying about the selection problem?

The I think we should do as good a job as we can in trying to determine some surrogate health status measures that might capture that question in this particular time period, because that's the question that we're asking.

So I would make a number of suggestions for you. In this time period, the Medicaid recipients were, in fact, not in Medicare managed care. So I would look at the proportion of poorer Medicare fee-for-service patients

because we know that they tend to have lower health status.

I think the age distribution is very important. I don't know how age is adjusted for in what you're doing.

I would look at the work by David Cutler who, I think, tried to do some work. I think I've got the right person. And he tried to do how much of the expenditure the geographic levels was accounted for by various health status measures. And he had some very creative health status measures that he tried to use.

And I think that the DSH has to be pulled out because the DSH is an artificial policy variable that has nothing to do with real utilization differences. So artificially inflated policy variables have to be pulled out because they've got nothing to do with resource utilization.

As I said, I would contact this David Cutler and try to get as many surrogate variables, not because you're going to use this to set the premium rates, but you're going to try to figure out, looking across this vast United States, the best I can do with all of the errors, what proportion of this variation is, in fact, associated with

health status differences and prices.

And you might come up with something. That's a very different kind of approach, but I think it gets closer to where Gail is and it provides some interesting information and maybe people have some ideas about things, in fact, that you might look at.

Now that's a very different kind of a question from going at and looking and saying what does this information tell me about plans? Because then I think you have to think about it a little differently if you're going to tell me what does this give me about plans. Unless you have a model that says plans are more likely to go into those areas for which the predicted value is -- I go through and I do my actual versus my predicted and I look at those places where, in fact, my expenditures are higher than they would be predicted.

You may say that may be where I'd expect the plans to go in. And where it's lower than it's predicted, that might be, unless you have risk selection, in which case you've lost a lot of the information.

That's the way that I think that I would go about doing this if the question is at a geographic level what's happening with health status and what's happening with residual practice variation.

DR. ROWE: Can I ask Judy a question about this? Taking DSH out makes sense to me to whatever extent it does not reflect any resource utilization. But to whatever extent DSH was invented and put in because it takes care of some variation in resource utilization, which was not adequately measured by the other things we used, DRG, volume, et cetera, then presumably it would stay in. Or some other factor would have to be put in. So how --

DR. LAVE: We know that that changes over time.

DR. ROWE: I'm sorry, I almost finished my question, but it's okay. I just couldn't resist.

DR. LAVE: My understanding is that originally in 1982, that there was a positive statistical correlation between cost and low income.

DR. NEWHOUSE: In Massachusetts, which was replicated later in national data but the national data --

I'm sorry. It was replicated for Massachusetts later with national data but the national data didn't show any correlation. In other words, Massachusetts was unique.

DR. LAVE: Yes, and then the national data changed over time so that --

DR. NEWHOUSE: No, the original study was just Massachusetts.

DR. LAVE: But it was Steve Long's study.

DR. NEWHOUSE: No, it was Arnie Epstein's study. And then Steve Long could replicate Arnie's finding for Massachusetts but couldn't replicate the finding nationally.

DR. WILENSKY: The point is that there is not --

DR. ROWE: What time is this class over?

[Laughter.]

DR. NEWHOUSE: Just in time for the next one.

DR. WILENSKY: -- that in fact it is reflecting higher resource use within the Medicare population. It serves a different function.

DR. ROWE: Okay, that's a different -- okay, that's a question. Is this like a one credit course?

DR. LAVE: It's CME.

DR. KEMPER: I was taking the kurtosis class.

[Laughter.]

DR. KEMPER: Judy, I just don't understand your comment that this doesn't speak to pricing and I don't think we have to wait for premium support because we have it within --

DR. WILENSKY: We had the same problem with Medicare and Medicare+Choice.

DR. LAVE: No, I'll tell you why I don't think that it speaks to pricing, is because if the fact that some of the variables that I am proposing that be used for health status are not variables that you probably could use in terms of setting a risk adjusted payment for the plans.

DR. WILENSKY: But you're saying it's indirectly. This is not -- there has to be another step.

DR. NEWHOUSE: At the end of the day you're still going to have a big residual that you won't know what's in there.

DR. KEMPER: But you're talking about how much is

explained at the individual level. It's going to explain more at the county level because it's a big sample or a bigger sample than at the individual level. So I think that's part of the exercise, is to figure out how much will be explained at the county level.

MR. MacBAIN: Just briefly. We haven't talked a whole lot about Scott's half of this thing. The question of the managed care plan production function, and I'm not sure that will be as fruitful an avenue.

It will be interesting to see where you get. It sounded like you wanted to do a regression of ACR costs against enrollment or something like that, sort of tease out the fixed cost component.

MR. HARRISON: That would be part of it, right.

MR. MacBAIN: And if the administrative costs, I think maybe Hugh mentioned this, if the administrative costs are calculated as a load then they're going to look variable. When you're done, even if you find something, I'm not sure what it tells us from a policy standpoint.

MR. HARRISON: The other thing we were hoping to

do was regress it on fee-for-service costs, to see what the curve looks like, and it might turn out that the plan's variation is much smaller than the fee-for-service sector's variation by county. And that might come at it from a different way, so you don't have the big problem of trying to figure out what the practice pattern differences are and how to pay for them.

DR. WILENSKY: Thank you. Jack?

MR. ASHBY: I'm sure as everyone is aware, the Medicare margin that we have been publishing for years for inpatient services has risen dramatically in recent years. As of the latest data we have, 1997, the national figure stands at about 17 percent.

But at the same time, we estimate that if the outpatient PPS and the adjustment for formula driven overpayment had been in effect in 1996, the national outpatient margin would have been minus 30 percent even at that time.

Now on the inpatient side, we as a commission concluded in the past that site of care substitution, by

which I mean transferring the last day or two or three of an acute care stay to a post-acute setting, has substantially reduced hospital costs without a corresponding reduction in Medicare payment obligations.

So MedPAC and ProPAC before it responded to that situation by developing a site of care substitution factor in our update framework. We have recommended a downward adjustment for site of care substitution in each of the last three years and our March report this year suggested that there are additional incremental adjustments yet to be made.

But the purpose of today's session is to explore at the conceptual level -- we'll be presenting data later -- but to explore on at least the conceptual level whether we should continue to rely on the site of care substitution factor or whether we should consider the broader option of rebasing.

Before we even get into this rebasing concept, I want to make clear that we do indeed recognize, in fact we agree with the industry contention that we should look beyond inpatient payments and inpatient margin to consider

the impact of our payment policies, and specifically the impact of the BBA, on all services that hospitals provide.

But at the same time we believe that ideally the base payment rates should be set at an appropriate level at each individual service. That's acute, rehab, outpatient and the like, rather than set an inadequate level across all services.

If all hospitals have the same proportion of mix of services, then the across-the-board adequacy would be good enough. But in fact, the mix of Medicare covered services varies all over the map and potential problems with payment levels being unbalanced among them are a possible payment inequity among hospitals and, perhaps even more importantly, resource allocation decisions or even patient treatment decisions are being made for financial rather than clinical reasons.

So while we will be addressing the question of whether payments for inpatient services may be too high, we by all means are willing and hopefully able over time to address whether payments for some of the other services that

hospitals are providing may be too low, as we connote in this first overhead.

Next I wanted to take a moment to define what we mean by rebasing. In the context of today's discussion we see rebasing as simply raising or lowering the base payment rate by some percentage amount to achieve a more appropriate alignment of aggregate payments to aggregate costs.

In the inpatient payment system we have just two base rates, one for large urban areas and one for other urban and rural areas. So while the issue is, by all means, a complex one, the final calculation step is a very simple one. A couple of taps on the calculator and you're there.

Rebasing is frequently assumed to mean that we are setting payments equal to cost. But for a number of reasons, some of which we're going to talk about in a minute, the appropriate payment to cost ratio may well be something other than one. It may be other lower or higher.

In the paper we raise some questions that the commission would need to consider in implementing a rebasing strategy, but before those questions even come into play we

need to address how we would go about determining what the appropriate level of payments is.

While we're going to focus on inpatient payments in doing that this morning, essentially the same issues apply if we were addressing the payment adequacy question for any of the other major services that hospitals provide.

In our March report, just this last year, we suggested that the first place to look for clues on payment adequacy is in a volume trend, the supply of providers, and any evidence that might be available regarding quality or access problems.

But particularly compared to some of the post-acute care services, the acute inpatient admission rate has been very stable going back 15 years. And there have been fairly limited changes in the number of providers, mostly through mergers. Although we are hampered by the lack of a comprehensive quality reporting system, I think it's safe to say that no evidence has emerged of systematic quality problems relating to inpatient care.

So learning relatively little there, the

assessment then turns to how closely payments do align to costs. It's suggested in the paper that there are at least six factors that make that question more complicated than it looks. Four of them bear directly on our margins calculation and two consider the broader picture.

The first of these factors is the impact of the several BBA payment cuts that do impact inpatient services. Or perhaps I should say the BBA payment cuts as amended by the BBA givebacks that may be legislated in the near future.

DR. ROWE: Corrections.

[Laughter.]

MR. ASHBY: The effects of some of these factors, particularly the ones affecting capital and outlier payments, will be seen in the 1998 data that will be presenting at the January meeting. But some of the others, most notably the expanded transfer policies, will not be seen in the 1998 data. And some of the others are spread out over five years.

One way that we could handle this is to establish a target payment to cost ratio now. That target payment to

cost ratio would be a valuable standard or guideline in its own right. And we might couple that with a phase-in schedule for the rebasing needed to get to that standard, and then adjust the phase-in schedule a couple of years down the line when we have more definitive data on the impact of the BBA.

I would suggest that we really don't need to wait until 2002 data are in to get the picture. I think we'll have a reasonably accurate picture when complete 1999 data are in. That's about a year-and-a-half from today.

Second issue is bias in the allocation of costs in the Medicare cost report. For the last 15 years hospitals have had an incentive to allocate as much of their costs as possible, particularly overhead costs but really all costs, to services that are paid for on a cost basis. That would be the majority of outpatient payments, home health, rehab, and until recently skilled nursing facility.

Ideally, when considering payment adequacy, we would want to adjust our inpatient costs upward to account for this factor with a corresponding downward adjustment in

any of these other services. At the December meeting we will be presenting the results of research that has addressed the issue of allocation bias, but two comments in advance of that.

One is that the adjustment we'd be talking about here is not trivial. This is a very important issue, even though it's been quite subterranean in analyses that have been done in recent years. The potential adjustment is quite large.

But the second comment is the research is quite limited. In the end, this is going to remain rather judgmental. You recall that Woody suggested a couple of meetings ago that this is an issue where we might want to do some additional research and I think that's a distinct possibility and we can talk about that as this unfolds.

The third issue is GME and Medicare bad debt expenses. This is a fairly easy one. Our margin calculations to date have omitted both of these cost elements. But with our recent report on teaching hospitals positing GME expenses should be considered part of patient

care costs, and with the BBA cutting Medicare bad debt reimbursement rather substantially for the first time, we obviously need to bring these elements into the measure.

We'll be making both of those changes for the data that we'll be presenting in December or January. Those changes will indeed reduce the margin for both inpatient and outpatient services.

The last of this set of factors is non-allowable cost. These are cost elements that Medicare does not recognize for payment purposes, such as patient television, telephone, and direct advertising. I've listed several other of them in your mailing materials.

Non-allowable costs make more difference than meets the eye. We think somewhere between four and seven percentage points. So that means to reach a common denominator our 17 percent margin would be on order of four percentage points lower if it considered all costs. Or looking at it the other way, the AHA data that we have used for these analyses would be four or more percentage points higher if they were based on the Medicare framework.

The important thing here is to understand which of the two we are dealing with, to understand the effect of the difference. But in the end it seems that we have little choice but to conduct our assessment of payment adequacy against the standard of costs that Medicare is legally obligated to cover.

Now, turning to other services besides PPS inpatient, the main idea that we wanted to float here for consideration is the possibility of implementing what you might call a transfer of funds among the services. If we did independent assessments and concluded that payments are too high for PPS inpatient services and too low for one or more of the other services -- and obviously I'm thinking of outpatient here -- then it would obviously make sense to fix both problems at the same time. It, at a minimum, would minimize the disruption to the industry of making fairly substantial changes.

The approach is not quite as clean when we're talking about SNF and home health because payment changes there cannot be directed solely at hospital based services.

Even between inpatient and outpatient, we shouldn't go into this with the notion that the overpayment on one side would equal exactly the underpayment on the other side.

DR. WILENSKY: Excuse me, I'm a little confused on the point that you're making. If there was an overpayment on one side I understand why you would want to make -- and if there are underpayments on the other side why you would want to make those corrections.

But with regard to the areas in which there are other facilities that provide those services, like home care and SNF, if there are inappropriate payments, wouldn't you want to correct them? And the fact that they don't all go to the hospitals doesn't make any difference?

MR. ASHBY: I think that's the bottom line right there. We just can't view that as a simple reshuffling of the funds in the hospital sector because the hospital sector has no bearing in Medicare payment policy. So we just have to be aware of that.

But I was just going to say that even if the changes just overlap, as opposed to coincide, it would seem

like there's some benefit to this transfer approach.

We are in the process of developing an all-Medicare margin. This will be a joint effort with HCFA. We thought that we should work together with them so that we have a common scale here and we don't have multiple numbers floating around. And we're hoping, of course, that those margin data will help you in assessing the relative payment adequacy of the major services hospitals provide.

Actually, by January we may only have a most of Medicare margin rather than an all-Medicare margin, because there are some daunting data problems to be dealt with. The data simply are not as well developed for some of the other services as they have been for inpatient services.

But at a minimum, our analysis at that point will include PPS inpatient services, PPS excluded units, and that's psych and rehab, the majority but not all of outpatient, SNF, and home health. Those are the major ones that I think that we'll want to deal with.

Lastly on this list of factors is the relationship between Medicare and private insurer payments. Medicare

fee-for-service and the entire private sector, including Medicare managed care, comprise roughly equal shares of hospital business nationally. They have 38 and 37 percent shares respectively.

So we can get a fairly good picture of how hospital payment source dynamics work by looking at just two variables, the Medicare and private payer payment to cost ratios. So if we can look at this next graph, you can readily see here -- and most of you have seen these data before -- you can readily see here that there was a major shift of payment obligation from Medicare to the private sector between 1986 and 1992.

And then since 1992, and that year by the way was roughly the point at which we began to see some real pressure in the private sector from private insurers, managed care organizations and other private insurers. And it also roughly corresponds to the point when we began observing site of care substitution. From that point forward, we have had a shift of nearly equal proportions back in the other direction.

But 1998, which is not yet on the draft, not because it's off the side of the picture but we don't have the data yet. We will have them in about February. 1998 may be a watershed year here, or at least '98-'99 combined, in that the BBA will almost undoubtedly turn that Medicare line downward again, as intended, while the downward pressure coming from private insurers is most assuredly continuing.

DR. ROWE: Is this total hospital or is this hospital inpatient?

MR. ASHBY: No, this is total hospital. It covers all services, down at the bottom.

DR. ROWE: Thank you.

DR. LAVE: Jack, we'll probably get to this. You've added up all hospital revenues and added up all hospital total costs, so you could have 101 hospitals in the United States, one very big one, very lush and the other 100 very impoverished, and you would still have this result.

MR. ASHBY: Right.

DR. LAVE: So I really think that we ought to have

some distributional data by hospital, rather than this number, in our report. This number conceals so much about what really is happening.

MR. ASHBY: It shows the trend --

DR. WILENSKY: But if all the little ones were the ones at one end, I mean the numbers -- we need probably to look at both.

MR. ASHBY: Right, I would suggest it's both. This shows an important trend but there's lots beneath the surface.

DR. LAVE: I agree with you, but it conceals what's happening to hospitals.

DR. ROWE: I think also -- and the economists can tell me, if it were right at 100 percent it would suggest that 50 percent of the hospitals are getting paid less than their costs and 50 percent are getting --

DR. NEWHOUSE: No, this is the mean and not the median.

MR. ASHBY: It's an aggregate, basically. Exactly, as Judy pointed out, you just sum up both sides.

DR. ROWE: Maybe Joe or Gail can tell me, as a non-economist, what the right number is. That is, if you had the capacity to decide what you were going to pay someone relative to their costs so that they could have a sustained operation, and invest in the future, and all the rest, what is that number? Is that 100 percent of cost, 103 percent of cost, 110, 92? What's the right number?

DR. NEWHOUSE: You've just raised a topic that goes by the name of rate of return regulation in the public literature. And the answer is that that kind of regulation induces its own kind of distortion. So it's not clear that there is a right number.

DR. ROWE: Sure. But the point is that drawing that line across at 100 suggests that 100 is the right number.

DR. NEWHOUSE: No. I'm sure none of the economists here would think that 100 is the right number.

MR. ASHBY: We weren't really trying to get at that in this. This is really to show the relatives between Medicare and the private sector which is an important issue

in its own right. But this payment adequacy discussion does requirement ultimately, I think, a decision as to what the right standard. So this is the direction that we're going here.

The question is whether we can really come up with a standard, whether we can answer that question. But if we don't, the question is answered implicitly by the sum of Medicare payment policies anyway. It's there whether we can define it or not.

DR. NEWHOUSE: We should say, there are a couple lines that aren't here that would be below 100 if they were, which is Medicaid and uncompensated care.

DR. ROWE: Other payers besides the private payers and Medicare.

DR. WILENSKY: It's who's subsidizing whom, but it's not clear that you would accept the cost structure as the one that you would want to -- that's the issue that goes without question in this. That you are, for the moment, are accepting without question. It assumes the cost structure is the cost structure that you want to live with. But it

does say who's subsidizing whom within a given cost structure.

DR. MYERS: Let's not assume either that the private pay number is a single line. There's some variation --

DR. WILENSKY: Of course not.

DR. MYERS: Some of us are far above that line.

MR. ASHBY: Right, there's a tremendous variation, and you'll recall we have a contract out right now, a major research project to get at some of that disaggregation that we have not been able to do in the private sector, and it's very important.

DR. ROWE: Unless I missed it, Joe, you finessed my question.

DR. NEWHOUSE: I did.

DR. ROWE: Isn't there somewhere in an Economics 101 textbook a number that says if you have a company or an ongoing thing you need -- you don't need 150 percent of your costs, but you need more than 30 percent of your costs, right? Isn't there some number that you need?

DR. NEWHOUSE: No.

DR. ROWE: There is no number?

DR. NEWHOUSE: No.

MR. ASHBY: There have been some suggestions by financial management people in the literature, but they're suggestions. They're what you want them to be.

DR. NEWHOUSE: There's a concept called the normal or competitive rate of return, but that doesn't translate into a number.

DR. ROWE: That's not the same as this.

DR. NEWHOUSE: That's the concept this would correspond to.

DR. KEMPER: At one level Jack can answer the question of what it takes to keep hospitals in business.

DR. ROWE: I know what the number is. I think Dr. Loop knows what the number is.

DR. WILENSKY: But you're not telling us.

DR. ROWE: Yes, I'll tell you. I think it's 104 percent.

DR. WILENSKY: 104 percent of what?

DR. ROWE: Costs.

DR. WILENSKY: But that's not fixed.

DR. NEWHOUSE: Her point is that cost isn't fixed.

DR. ROWE: If on average I collect 104 percent of my costs, that gives me enough money to continue --

DR. WILENSKY: But the point is, how you define cost. I don't mean technically how you define it or what you include in it. I mean how you produce the services that you do --

DR. ROWE: That's a different question. You asked me what the number was. I'm saying, if I look at my P&L at the end of the year and I look at the expenses at the bottom -- I have my revenues and I have my expenses. If I can bring in 103 to 104 percent of those expenses then I have enough to keep --

DR. WILENSKY: If you had return to capital, presumably it would be 100. The only question is again, relative to what?

DR. ROWE: Right. At least I answered. I didn't finesse it.

MR. ASHBY: And that is within the range of numbers that I quoted in the financial management literature, 104, 106, something in that territory. But I think we have to agree that those are numbers not so scientifically based.

DR. MYERS: Is that 104 before or after endowment and all the other sources that are outside of private --

DR. ROWE: These are expenses, not revenues. It would be, obviously, 104 percent of expenses. But I would say it would include the income from endowment. It wouldn't include its endowment, but it would include what comes in through the income from endowment, or all sources.

DR. MYERS: That's what I meant, which varies substantially. So I'm wondering, your number is 104. His number may be 106, 103.

DR. ROWE: I agree.

DR. NEWHOUSE: I think one issue is that to some degree payment drives cost as opposed to cost driving payment.

DR. ROWE: I think Gail's question about, are

those the right costs and what is the right cost structure is a very important question. But it's a different question than, on average, how much of your costs do you have to recoup in order to sustain the organization. Those are two different --

DR. WILENSKY: Because return to capital is 100 percent.

DR. ROWE: Gail wants the right cost structure. But even if I got what Gail would accept as the right cost structure, once I'm there I still have to decide how much I have to recoup in order to sustain it.

DR. WILENSKY: And if you define your costs correctly it would be 100 percent in the short term in terms of return to capital. But again the concept, it's really the notion of how you're defining the cost structure, especially over time, given the different ways of producing it. What we've seen in this sector that there has been a drive to lower costs in the mid 1990s, which is the way, as

we discussed before, the way we have gotten to the high margin position as of 1997 wasn't increased revenue, it was the change in cost structure. So it again reminded people that cost structures and processes and technological changes change what costs look like.

DR. ROWE: I think this is actually a good discussion and the kind of discussion MedPAC should be having. I got into it by just suggesting that the non-cognoscenti which assumed that 100 percent was the right number, and we shouldn't assume that.

MR. ASHBY: My very next point was going to lead exactly where Jack was going and that is that we have to ask the question here of how much responsibility does Medicare have for falling payments in the private sector. It seems that the answer is that we need to have a rough standard of where Medicare needs to be.

Then I would add to that that if we're talking about a change to get there, it probably needs to be done rather gradually because Medicare's payment policies can and obviously do affect the dynamics of payment negotiations in

the private sector. It takes time for those processes to take their course. That has, I think, been part of the problem with the BBA is that some of this hit rather suddenly and in large quantities and it takes time for that to have its permeated effects through the private sector.

Now just a couple of quick things and then we can open it back up for discussion. On our next slide we suggest two possible advantages to the rebasing concept over the site of care substitution adjustment that we have been using. First is that the site of care substitution has proven to be stubbornly difficult to measure. We've had a lot of frustration over this, as most of you recall. It's difficult to measure as an independent factor.

Secondly, is that rebasing and simply setting a standard payment to cost ratio implicitly accounts for other factors than site of care substitution that have indeed played a role in the rising margins, and we suggest three of the key factors here on this slide.

Next, we suggest four questions that the Commission would need to address in order to pursue this

rebasing option. Actually, I think that we have covered in our discussion three of the four here and no need to backtrack. But I did want to touch just briefly on the expanded transfer policy. We are going to be planning a separate session on the expanded transfer policy in December so we don't want to get into the merits of it now.

But the one point I wanted to make in the context of today's discussion of payment adequacy is that we really don't see the expanded transfer policy as being a payment adequacy issue. Basically it's a distributional issue and your decision on whether the policies should be extended to more DRGs, or for that matter whether it should be retracted to no DRGs, would ideally rest on whether you think the policy improves the incentives involved and whether it produces a more equitable distribution of payments.

One of the implications of that notion is that we could set up a phase-in schedule for either a rebasing or a series of annual site of care substitution factors that holds the aggregate impact of extending the transfer policy to more DRGs to some described minimal level. In fact it

could be zero. The idea of expanding the transfer policy would not be to save money. It would be to create a different distribution of payments that we think is better.

With that we go to the underlying question, should we continue with our site of care substitution approach or should we prepare for this rebasing option when we come back in December or January?

DR. NEWHOUSE: Before I throw it open, let me respond a little bit more precisely to Jack. The issue would be 100 plus X percent of what? If it's of cost, that's basically cost-plus and the literature would say that gives everybody incentive to keep expanding their costs forever. If it's a percentage of capital, which is the Con Edison case, then it gives you an incentive to add to your capital base, substitute capital for labor and so forth, so you wind up with excess capital. Actually we had an analogy with that in the early PPS when we passed through capital and capital as a share of total costs went from 6 percent to 9 percent. But that's the more precise answer I think.

DR. ROWE: And what's your opinion?

DR. NEWHOUSE: I think in this case we're actually talking about -- first of all, Medicare, this is a more complicated case and it's going to take us -- because Medicare is only one payer.

DR. ROWE: No, forgetting Medicare. In other words, if you were running a hospital, what would you think would be the right number, an all-payer, all revenues number based on what you know as the world's leading health economist?

DR. NEWHOUSE: I don't know, I think there are some other leading health economists.

[Laughter.]

DR. NEWHOUSE: I'm reminded of what my old college roommate used to say which is, when your outgo exceeds your income, your upkeep is your downfall. So if I'm running a hospital I'd need to be over 100 percent. I don't know how far you need to be over.

DR. KEMPER: Just a comment, Joe, in terms of the incentives of cost-plus. Since this is being done at an aggregate, sort of national level, that's not the same as

cost-plus reimbursement at the hospital level. The hospitals still have their incentives to cut costs, so it may not be quite as big an issue of incentives.

Jack, the question I wanted to ask was -- at the risk of embarrassing myself -- could you just tell us at an elementary level what the rebasing involves and how it's fundamentally different from just increasing the update?

MR. ASHBY: It's not really all that different. We would be talking about deciding that we need an X percent change in the underlying payment level, and that we want to implement that in half-percentage point increments, or 1 percent increments, or whatever, which as you recall is not overly different than what we do with the site of care substitution. It ends up being implemented through the update anyway in annual increments.

The difference comes in the initial process of deciding how or what kind of adjustment to have. With the site of care substitution factor, we were endeavoring to make the size of the adjustment such that it captures how much site of care substitution there has been. This offers

you the possibility of saying, you don't really need to tie it exactly to that, we just need -- so that we're implicitly adjusting for whatever factors have resulted in this misalignment that we currently have.

I wanted to make one other comment relative to this discussion that we've been having over here. Joe was pointing out the traditional cost-plus problem, that it gives you an incentive forever to keep increasing your costs. But I wanted to point out that in this rebasing you are making a one-time adjustment to get to a point that you think you want to be. The idea is not to then maintain --

If we set it at 104 percent, for example, the idea is not to make sure that we maintain 104 percent indefinitely from that point. It's only the starting point. Then it is the updating process that determines where we go from there, which would indeed allow the payment to cost ratio to change over time, and would provide a means of counteracting the underlying incentive to keep raising your costs. In that context, you keep raising your costs, the update is not going to follow those costs and there will

begin to be financial pressure once again.

If we didn't do that we would be, in essence, back to an aggregate cost-based payment and I don't think anybody wants to go in that direction. We just want to set an appropriate base and then update it appropriately.

DR. KEMPER: But, Jack, just to follow up. So the rebasing is really an update with a different name and a different philosophy.

MR. ASHBY: Right, and probably a different amount.

DR. KEMPER: And probably a different amount. But it's still just changing the rate up or down overall without any refine --

DR. ROWE: It's instead of using 1984 trended forward; is that what you're saying?

MR. ASHBY: Yes, in essence, I guess you could say that too, right.

DR. ROWE: That's what we're doing now, right?

MR. ASHBY: Right. The other difference on the practical side is that you make a statement once as to what

base you want to be at and we're then making adjustments to get to it. In the updating philosophy, at least as traditionally applied here, we have not been making a one-time statement about where we want to get to. We're making annual statements of the change that's needed.

DR. KEMPER: But the world will change before that implementation, before that phase-in is done so we'll be back to some adjustments.

MR. ASHBY: Right, given how dynamic these are.

DR. NEWHOUSE: Maybe one way what you're describing would be a mid-course correction.

MR. ASHBY: Right.

DR. WAKEFIELD: Jack, before you get to the questions that you have up on the screen, you have in our document sort of the fundamental question that you start with, are Medicare PPS inpatient payments too high? Obviously, the driving concern for me from my perspective is, are changes in payments that jeopardize access for primarily rural Medicare beneficiaries. So that's my fundamental concern on this -- on most fronts, obviously,

given most of my comments.

It's especially a concern for rural hospitals, I think, given the data that indicate that the negative total Medicare operating margins, if you look back to fiscal year 1995 for urban versus rural hospitals, or rural versus urban I should say, were 15.9 percent versus 9.8 percent. So those statistics reflect a financial condition that existed then before BBA implementation. So we start from not the healthiest financial set of circumstances for rural hospitals for starters. Then also being mindful, of course, that rural hospitals have a pretty high -- depend more on Medicare reimbursement than many of their urban counterparts.

The question for me is, are you planning on cutting -- the first question, are you planning on cutting these data so we can try and capture differential impact in terms of PPS inpatient payments, in terms of coming to a conclusion about whether or not inpatient payments are too high? That's one question.

Then the second is, I want to say I really like

the fact that we're looking at inpatient and that you're also considering as part of this document the cumulative impact of the other PPS changes, SNF, outpatient, home health. Because again, for at least two out of the three there's, two out of those three have real serious implications for rural hospitals because of rural hospitals' attempts over the last few years to integrate those services into their delivery systems. So that's one point.

It's hard to separate out the mother ship and the adequacy of payment for the mother ship now that we've got these other satellites out there that are -- your points earlier, that are drawing down. And to the extent that they may or may not be adequately paid, obviously that then flows back to affecting the fiscal health of the hospital itself.

So to that second point then, in terms of cumulative impact, I just would like to draw your attention to two studies and I'll give you copies of both of them, one done by WAMI, the other one by Project HOPE that I referenced yesterday, looking at the implications of the BBA for rural hospitals, especially focusing on what, from those

two studies, they ascertain are happening in part due to BBA changes, what are happening to the financial conditions of the rural hospitals that they were looking at. So I just want to make sure that you have the opportunity to take a look at both of those studies.

MR. ASHBY: I think though that the issue that we're talking about here is largely one of how much money is in the system, and the issues that you're talking about are essentially distributional issues.

Once having established the amount of money in the system, there are myriad of ways to affect the distribution of payments that can get at some of the issues that you're talking about. Some of those ways are in the proposals that are floating through the Senate and House as we speak. There are others, including the disproportionate share adjustment that Deborah Walter is going to be telling you about in just a few minutes that would very much affect this relationship.

So I would really suggest that the issue we're talking about here is really a single issue of how much

money there is in the system. Then we need to turn to --

DR. NEWHOUSE: And I would say and its allocation by product line, if you will.

MR. ASHBY: Right. Yes, among product line. But each of those product lines has urban, rural, and a variety of other distributional effects. But there are other mechanisms, I think, for getting at those distributional effects.

DR. WAKEFIELD: As long as somewhere in this whole process we get at that distributional effect and any differential impact that it might have on rural versus urban, given the stats that I just briefly mentioned at the beginning of my remarks.

MR. ASHBY: Right. As I said, we're in fact about to do that in a just a minute.

DR. MYERS: If you do pursue the rebasing, I'd be very interested in all the assumptions that you're making when you do that. I worry about what happens to a hospital who has really paid attention in the last five to 10 years, has become very efficient, has invested in systems, who's

got its productivity up at the highest levels versus a hospital that's had bad management, who really hasn't paid attention to quality.

DR. NEWHOUSE: This isn't hospital-specific. Peter is right, you should think of this as kind of a change in the update factor.

MR. ASHBY: Right. The efficient hospital is still going to have the same rate as the inefficient hospital, all else being equal, if they're next to each other, so one is going to profit more than the other. That was true before and it will continue to be true even if we have this rebasing.

DR. MYERS: Then let me just go back to the beginning. I would really be interested in you explaining, listing all of your assumptions as you talk about rebasing involves, what it means, because I think that -- at least I'm not really clear on exactly how that would work.

MR. ASHBY: I think one of the ways that it helps to get at that is to consider how we come up with our payment rates. It starts with just one number and it's that

one number that we're talking about changing. But from that number it gets realigned according to what DRG the patient falls into. It gets realigned according to where in the country the hospital is. It gets realigned for a variety of other things that determines the payment rate.

DR. NEWHOUSE: When you say the one number, you mean the conversion factor?

MR. ASHBY: Yes, the conversion -- it's in other sectors frequently called the conversion factor. We call it the standardized amount in this. A different history, I guess. But it is the conversion factor.

But that's the main point, is that there are a variety of other adjustments to this one number that determine any hospital's payment. We're only talking about changing the first number in this series of calculations and that's why it adjusts the amount of money in the system.

DR. LAVE: My sense is that this issue gets us into almost a theological kind of debate about what we're going to call the apple, and the apple is how much we're going to pay the hospital. Conceptually, I prefer the idea

of rebasing as a conceptual model only because it seems to me that we are saying that we think that at the moment that the base payment rate may be too high, and that we may want to adjust it downward and then start again inflating that going up.

The problem that I have with looking at the data, deciding that in fact the difference between the base payment rate and how much hospitals are getting is too much -- which is what we're doing -- we then go through a number of exercises to try to assess why it is that we want to bring it down. So we decide we want to bring it down, and the main reason we want to bring it down is because the nature of hospital practice has changed fairly dramatically from the time that the system was first put in place. That the hospital administrators and physicians have engaged in a set of practices to control their costs either by increasing their efficiency or changing their transfer policies.

I just think -- I'm more comfortable with deciding, the world has changed, why don't we acknowledge that and use this as a target rather than trying to sort out

the various reasons that have taken place to bring down the costs and decide which ones of those we think are okay and which ones of those we think are trying to get costs that were not in the base that were in the base to begin with. So my guess is we're going to end up in exactly the same place, so what kind of terminology do we want to use to justify how it is in fact that we got there? Because I think we'll probably end up with exactly the same amount of dollars or recommendations that we are going to recommend.

So as I said, I think it's kind of -- it's a discussion about how do we want to frame what it is that we want to recommend, because I do believe that the main reason that we're doing this is because there is a difference between the costs and the payment rates that are generated as a result of hospital behavior and how it is that they manage their inpatient costs, which is different from the way they managed their inpatient costs in 1982 or 1989 or 1995.

MR. SHEA: Is there any difference in the age of the data that we use in these two approaches?

MR. ASHBY: Our attempts to measure site of care substitution in the past have been on slightly older data. But I don't think that's really the point. The point is that in the end there really was no way that we could all agree to do the measurement. So whether the data is old or not is kind of secondary.

MR. SHEA: I mean between these two approaches we're using the same year's data?

MR. ASHBY: Yes.

MR. SHEA: It just seems to me that things have changed, as Judy says, and things are changing. When you think about some of the factors like prescription drug cost for inpatient care, if we're talking about making major changes here and we're not capturing those -- and we're probably not if we're at more than a few years' old.

MR. ASHBY: No, either way we would use the most recent that we can get our hands on.

MR. SHEA: And it would be roughly the same is my point.

MR. ASHBY: Right, and we're making some moves to

try to bring in even 1999 data into this picture, and that would be the case either way.

DR. KEMPER: I guess first I have a question of Judy. I agree with you conceptually this is easier so now I would have an update that I could understand. But would you then see carrying that through as each year -- that being the principle -- rather than --

DR. LAVE: All I can tell you is the way that I had originally conceptualized this whole prospective payment process, and my original conceptualization, which I guess somehow or other I have in the back of my head, is that you start off basically paying hospitals their costs, which is what we did. Then you have a set of rules about how you're going to increase that over time hoping in fact that that will generate a set of incentives to modify, be more efficient because you're moving away from costs.

Then after a while you do this for a while and then you reassess and say, do I like what I have generated? Is this a good thing or is this a bad thing, and then you basically rebase or do a mid-course correction or whatever

it is. Then you sort of look at your base and maybe start again. Now that is the way I conceptualize rebasing.

What has happened is that there were these set of rules, and they were in place for a while and then they said, this set of rules is giving us too money so they changed them a little bit. Then they said, this set of money is giving us too much money because we're looking at -- so rather than putting it on auto-pilot there have always been these adjustments as you in fact have gone through.

Then that kind of worked okay until the private sector really began to -- I mean, I think this is the story -- really began to tighten up. Then we saw this fairly significant change in cost pattern on the part of the hospitals whereby in fact a number of hospitals shed -- as Woody put it, they became extraordinarily efficient. The major teaching hospitals as a group have had a decrease in their average cost per case over the last three years. So you saw significant behavioral changes and have gotten to where we are now.

So the question is, do you want to call what

you're going to do a mid-course correction to bring them together? And you can call them a mid-course correction and bring it down. You can call it the site of care correction and bring it down. Or you can call it, God spoke to me and said bring it down and you bring it down.

But to me, the honest thing to say is, today the revenues are higher than the costs and I don't think they should be that much higher. Therefore, I think there should be either a rebasement or -- you can have sort of a target base or just a lower increase.

DR. KEMPER: What would you see doing the next year, and the year after that? Because things are continuing to change.

DR. LAVE: Things are continuing to change and I think it justifies a lower update factor. I would be very uncomfortable personally with a negative update factor, but that's just because I'm a kind person. And we could call it moving towards a better base, or a site of care substitution. I guess my problem is that I'd rather say what we're doing rather than give it a label. But that's

just the way I look at the world.

DR. KEMPER: But I think this data question of how recent the data are is very important because --

DR. LAVE: You want to make sure that if you're going to rebase and correct, you want to make sure that you're moving towards a number that is real and well-calculated.

MR. ASHBY: And reflects the policy decisions that have already been made.

DR. LAVE: Right.

DR. KEMPER: But I think this year is a good example. We've got two-year-old data on profits and margins but we've got all these BBA changes that make the world very different.

DR. LAVE: So it may very well be -- if it turned out, for instance, that for some reason the Medicare inpatient margins were going to be negative next year, I think none of us would say we want to rebase. Our sense about the value of rebasing would be very different. But that's, as I said, everybody has a very different way of

looking at it. I think if the inpatient margins turned out to be negative next year we probably would all forget about the site of care substitution, or there would be much less support for the site of care substitution.

MR. ASHBY: Can we interpret this as an interest in pursuing this option? Judy seems to be saying so, and I'm not sure whether we have a consensus here.

DR. NEWHOUSE: No, I haven't heard any disagreement with the overall framework you presented for leading us through this.

MR. ASHBY: Okay, then it will become one of the many issues where the devil is in the details, because how to figure out what the impact of provisions that are already in place will be is not an easy question, especially since some of them haven't passed yet. They're maybe going to pass in a couple of weeks.

Then I also want to remind you once again about this bias in the underlying cost data. By the time we get done adjusting for that, we may not be as far away from the target point as our current margins data would suggest. So

we'll be dealing with that then at a follow-up meeting.

DR. WILENSKY: Thank you. Deborah?

MS. WALTER: Disproportionate share payments, or DSH, are distributed through a hospital-specific percentage add-on applied to the basic DRG payment rates. Consequently, a hospital's DSH payments are tied to its volume and mix of PPS cases. The add-on for each case is determined by a complex formula and a hospital's percentage or share of low income patients. The percentage is the sum of two ratios, Medicaid patient days as a share of total patient days, and patient days for Medicare beneficiaries who receive SSI as a percentage of total Medicare patient days.

But this low income share adjustment has longstanding problems with measuring care to the poor, most significantly omitting uncompensated care. Also problematic is that payments are much more generous in payments to urban hospitals with 100 or more beds than to smaller urban and rural hospitals. Medicare's special payments to hospitals that treat a disproportionate share of low income patients

could be made more equitable by using a better measure of care to the poor and a distribution formula that more consistently links each hospital's DSH payment to its low income patient share.

Our presentation proposes three alternative ways of funding and distributing DSH payments relative to the current distribution of payments for the Commission to consider. It builds on the work conducted in previous years whereby MedPAC recommended to expand the measure of share of hospital's low income patient load which is used to distribute DSH payments to include all low income patients.

They also recommended to establish a minimum value or threshold for the low income share that a hospital must receive or must have before payment is made. In previous years, the recommendation was a threshold that would allow between 50 percent to 60 percent of hospitals eligible for payment. MedPAC also recommended that the same distribution formula be applied to all hospitals.

The distribution that was previously recommended would minimize favorable DSH payment adjustment to urban

hospitals. In creating urban-rural parity, however, a significant portion of DSH payments would be shifted from large urban hospitals to smaller and rural hospitals. Given the impact that other provisions of the BBA, we are concerned that such a dramatic shift may unduly burden a significant proportion of hospitals in urban areas that currently receive DSH payments, many of which are teaching hospitals.

So the purpose of our current work is to examine alternative funding options that will uniformly apply the same DSH distribution formula to all hospitals. That is, rural hospitals and urban hospitals of less than 100 beds, as well as to large urban hospitals while minimizing the magnitude of the redistribution of DSH payments from urban to rural areas.

The simulations that we're going to present are based on the Commission's previously endorsed low income share definition and threshold alternatives. Compared to the existing DSH formulas, MedPAC's approach is fairly simplistic. In creating urban-rural parity, a single

distribution formula for all hospitals would replace the 10 widely differing formulas under current policy.

The required low income patient cost data could be obtained by a straightforward means without using a complex cost allocation process like that in the Medicare cost report. The only data needed would be the charges for each of the low income patient groups along with the total patient charges.

Changes to the distribution and amount of DSH payments that hospitals receive were tested under three separate policy options. Again, we are seeking the Commission's input as to whether you wish to endorse one of the three options. Briefly, I'll just go through and explain what the options are.

Option one maintains current total PPS payments while allowing a portion of the DSH payments to be shifted from large urban hospitals of more than 100 beds to smaller urban hospitals and rural ones. Current total PPS payments would be redistributed, affecting both the hospitals that are eligible for DSH and the amount of DSH payments

received. Our previous simulations were based on this option.

The second and third options involve redistributing an amount comprising the current DSH money plus the amount needed to bring smaller urban and rural hospitals up to parity with large urban ones. Option two increases total PPS payments. The current amount of DSH payments going to large urban hospitals would be redistributed among these hospitals while the DSH payments to smaller urban and rural hospitals would be increased by infusing new money.

Option three is similar to option two except that that additional amount of money needed to create urban-rural parity is determined and then a budget neutrality factor, which is essentially a tax, would be applied to the total PPS payments of each hospital. That is, hospitals that are currently DSH and those that are not currently DSH hospitals. Our simulations suggest that the budget neutrality factor would be .7 percent, and it's easiest to think of this factor as a payment adjustment downward by .7

percent in order to hold total spending in the program constant.

In general, the results of our simulation found only modest differences in the proportion of PPS payments that hospitals would receive when the threshold eligibility is broadened from 50 to 60 percent of PPS hospitals. So for simplicity for the presentation, and as you'll see in your paper, we just focused on the 50 percent threshold.

But I think more importantly, the money needed to bring smaller urban and rural hospitals up to parity with large urban hospitals ranges from $540 to $553 million. This represents about 12 percent of total Medicare DSH spending which has risen to $4.5 billion in '98.

These next several slides are just basically tables of what our simulations have found. It should be noted that additional tables are presented in your paper and we have the ability to create more kinds of tables should the Commission wish to endorse any of these particular options. Also, just be aware that the numbers in option three show the percentage of hospitals that gain or lose

before the budget neutrality factor is applied.

DR. WILENSKY: Deborah, I have a question of fact before we get into the discussion. What I had heard and what appears consistent with the tables that you distributed is not as you've described it, which is it is a shift from urban to rural, but rather it's shift from private non-profits or other privates to publics, and that that's what is really causing a lot of the discussion that I have heard. When I look at the tables, indeed, the biggest shift is the very substantial increases that are going from the private -- -- I don't mean private investor-owned -- private non-profit and private to the public hospitals as opposed to this notion of a big shift going from the urban to the rural.

I guess what I'm not sure about is, why is that happening? Is there something in terms of the definition of unsponsored care, or counting the direct appropriation that we're not accounting for, or is there just something else? Because when I heard it I didn't understand why that was going on.

My impression was that what we were trying to do

was to have the same threshold for urban and rural, which I think is very strongly justified, and I'm disturbed by this notion that what we've done is something taking out of urban and shifting to rural, where it really is that we're taking this disproportionate share money out of the private not-for-profit or private for-profit and moving it directly into the publics.

I don't quite understand, is there something in our definition that has done that? That really, it seems to me, is by far the much more significant redistribution.

MR. ASHBY: That's somewhat deceiving, particularly since --

DR. WILENSKY: That's what it looked like the table showed.

MR. ASHBY: I understand. But the first thing to remember --

DR. ROWE: That's what it says, 6.2 percent.

MR. ASHBY: The first thing to remember is that there are many, many public hospitals in rural areas that were left out of the disproportionate share system

altogether in the past. So that when we talk about the shift from urban to rural areas and the shift from private to public, the two overlap considerably.

DR. WILENSKY: I cannot believe that the public rural are going --

DR. ROWE: It says public major teaching. Are there many rural public major teaching hospitals?

DR. WILENSKY: This is not convincing me, but go ahead.

MR. ASHBY: When you look at the aggregate shift to publics, that's what many of them are.

DR. ROWE: Who are they teaching?

MR. ASHBY: But secondly, if you recall our discussion when we made this recommendation, we noted then that there was some shift to public hospitals and we had some concern about that. It comes about basically because you are counting all low income care, basically uncompensated care, and that's where much of the uncompensated care is in public hospitals.

DR. WILENSKY: But weighted by how much Medicare?

MR. ASHBY: Weighted by how much Medicare they have, and they tend to have less Medicare. When you put those two together, less Medicare but more uncompensated care, the amount of uncompensated care is large enough that it still does swing some of the payment from private to public hospitals.

In our discussion two years ago we dealt with this primarily by saying that if you lowered the threshold to allow more hospitals into the system, you minimized the shift from public to private. And when you come down to the 50th percentile, half of the hospitals, it's a considerably smaller shift than it would be if we narrowed the payments. If you made a further jump down to the 60th --

DR. ROWE: I remember we had this curve up there of what the impact was and we were looking at -- and we were arguing about what number to pick because we were starting from 40, as I recall.

MR. ASHBY: Exactly, right.

DR. ROWE: 40 percent of the PPS hospitals. And I thought we had come to agreement that it would be between 50

and 60 percent of the hospitals.

MR. ASHBY: Exactly. Now this run is for 50 so it's going to have a bigger swing to public than if we ran it at 60.

DR. ROWE: So this is the result of 50. What would be the result of 60, roughly? That may fix this.

DR. WILENSKY: I'm more concerned with this issue -- to the extent that it's a Medicare issue, although as Judy had remarked earlier, the relationship that presumably drove this in the first place doesn't actually exist. But to the extent we're using Medicare money, it seems to me to have the number of low income dominate is not a compelling or satisfying response relative to the number of Medicare -- having it be determined by what's going on with regard to the Medicare population.

MR. ASHBY: Why don't we put up the table that has the --

DR. WILENSKY: Again, my concern had been the description that what we were correcting was to move away from --

DR. ROWE: It's the third page of your table.

DR. WILENSKY: -- urban to rural, because I don't think that's what we're doing. I think it's much more the shift from private to public and is that what we want the Medicare monies to do.

MR. ASHBY: Right. Here is where we have the scoreboard on that, if you will.

DR. ROWE: This is the 50 percent option?

MS. WALTER: They're all 50 percent.

DR. ROWE: Now on your first slide, Deborah, if I may, I think it's a little misleading because what you say is, establish a minimum threshold for low income share that a hospital must have before payment is made, reasonable range 50 to 60 percent. That implies that 50 to 60 percent of low income share. What you meant to say is 50 to 60 percent of hospitals.

MS. WALTER: Hospitals, yes.

DR. ROWE: So you need to clarify that because if you make it 50 to 60 percent of low income share it's going to be 10 percent of hospitals.

MR. ASHBY: Exactly right. But here's the scoreboard that you're speaking of, Gail, and it does indeed -- you can see the increases in payments are a little larger for public hospitals in each of those categories than they are in the private. If we were to use the 60th percentile instead of the 50th, the swing towards publics would be smaller than what you see here.

DR. WILENSKY: It strikes me that -- again, I raised this during your presentation because it struck me that characterizing this as whether or not you want to temper the movement from urban to rural belied what we're really doing is swinging money from the private to the public, and whether or not that's -- it happens because have a broader definition of low income to include uncompensated care. But somehow whether this is what we really meant to do with Medicare DSH money, as opposed to Medicaid DSH money.

DR. KEMPER: I'm having trouble understanding what options two and three are. I know the difference between two and three. I can understand that difference. But

whether it's an increase or just an across-the-board cut. But what I don't understand is, how does it differ from option one which had logic to it and expanding the base to include uncompensated care. You're doing something additional to the rules for allocating this, but I didn't understand what the something additional was.

MS. WALTER: In option two we're holding the large urbans budget neutral but we're adding more money, we're infusing more money to bring the small urban and rurals up to parity.

DR. KEMPER: So basically it's applying the principles that we developed a while ago, that you all developed a while ago.

MR. ASHBY: Same principles.

DR. KEMPER: But only to the rural hospitals.

MS. WALTER: In option two.

DR. KEMPER: You hold the urbans constant the way they are right now?

MR. ASHBY: No, you're applying the same

principles to them all, but you're putting new money in the system to allow rurals to be treated on the same footing as urbans.

DR. ROWE: As opposed to taking it from the urbans. They're just adding more.

MS. WALTER: Right. We're not disadvantaging urbans, we're just giving more money to the rurals.

DR. NEWHOUSE: That's two versus one.

DR. KEMPER: I still don't understand what the options are. The first one is implement what we recommended last year or the year before. The second one is then what?

DR. ROWE: Is to help the rurals by adding more money to the system rather than taking it away from the urbans to give to the rurals.

MR. SHEA: But at the same time as we're implementing the new rules.

DR. KEMPER: But the new rules affect everybody, it has effects everywhere.

DR. WILENSKY: So under option two the threshold is the same for urban and rural?

MS. WALTER: Yes.

DR. WILENSKY: It includes the broader definition of the uncompensated care?

MS. WALTER: Yes.

MR. SHEA: Just you finance it differently.

DR. KEMPER: So it's just implementing it but not in a budget neutral way.

MS. WALTER: Correct. Options one and three are budget neutral, if that helps you at all, and option two is not budget neutral by virtue of adding new money into the system.

DR. ROWE: Option three though is a redistribution of current Medicare funds, whereas option two is actually money; is that right?

MS. WALTER: Right. In option three we add new money but then we take away a certain percentage from every hospital.

DR. ROWE: So it is budget neutral.

MS. WALTER: Option three and option one are budget neutral.

MR. ASHBY: I think another way to look at it is, the original option one, the original way we did implementing the principles that you know was simply to take a pot of money and distribute it among all the eligible hospitals. So I think you can see, when you increase the size of the pot, obviously, all those hospitals are affected by it.

But you could increase the size of the pot and distribute it among everybody. But instead of doing that what we did is said, we're going to increase the size of the pot but instead we're going to have two pots now. We're going to divide them into two parts. The one for large urban hospitals takes their pot of money and distributes it according to the new principles. The second pot is increased in size and then too the money is distributed according to the new principles.

So the net result is, everybody lives by the new principles but there's more money in the rural pot.

DR. WILENSKY: How about if we were to do something like take $500 million and redistribute it to the

places that have sicker patients? Maybe this is just making clear that a disproportionate share program under Medicare doesn't make a lot of sense. But the notion that what we are doing is fundamentally providing substantial increases to the public hospitals who are not the major treaters of the Medicare population but they do have an awful lot of uncompensated care individuals.

The empirical result of what we're doing maybe makes what was a questionable program even more questionable in terms of Medicare monies, and especially if we're going to talk about putting a half-billion dollars more into the pot. We've talked in our GME discussions about trying to have a better measure of severity and instead of doing a budget neutral redistribution among DRGs, if we were going to do anything to help institutions treating Medicare patients, I'd much rather see the institutions who treat -- not do that budget neutral.

So obviously other people need to weigh in on how they feel about this. It may say, now that we see the implications of what seemed in principle to make some sense,

we may need to go back and say, exactly what is it that we're going with this program in terms of being a Medicare program?

DR. KEMPER: But you're asking for a reconsideration of our earlier recommendation.

DR. WILENSKY: Now that I'm seeing the empirical implications, which are very distressing.

DR. ROWE: The way I'm interpreting your remarks, Gail, is that we made a recommendation. They've gone and done the analysis. Here is the result. You're interpreting this as representing --

DR. WILENSKY: It makes no sense.

DR. ROWE: -- an unintended adverse effect here. We didn't expect that this would be it, and this is not worth the candle is what I'm hearing from you because it's not the intention.

DR. WILENSKY: From my point, yes.

DR. ROWE: So the question from my point -- and I don't disagree with what you say at all. My question would be, if you went to 60 rather than 50, how much of this

unintended adverse effect would get diluted out? Before we throw the whole baby out with the bathwater.

MR. ASHBY: There would still be some, just less than what you see.

DR. ROWE: But the question is, how much less? Because what you've got here is a doubling of the amount that's being distributed to this one class hospitals versus this other within the urban environment. So the question is, you're at 5.7, 3.3., and 6.2 --

DR. WILENSKY: This is not a small difference. As we look at differences, this is not a small difference. I mean, this is a doubling.

DR. ROWE: Yes. So the question is, if you went to 60, do you know now what the numbers would look like?

MS. WALTER: We do know that. I didn't bring them.

MR. ASHBY: We do, but not anticipating this was going to be the focus of today's discussion, we don't have the charts with us.

MS. WALTER: I can provide those.

MR. ASHBY: We can look at that again next time.

DR. WILENSKY: It may mean we have to wait. And that's a fair comment. It's just when I'm looking at these numbers -- and again, it's nothing against the public hospitals but we know that they are not actually the places that have very large numbers of Medicare populations. They just have very large numbers of uncompensated care, and that is swamping what we're seeing. I was very supportive of having a comparable threshold in urban and rural, and that wasn't a problem for me. So I really don't like this notion of characterizing, switching money to the rurals. But it does seem that this is an unintended consequence.

So we can see if there's a way that we can make more sense or what provides more sensible empirical results, and/or think about retargeting what this program was supposed to do, particularly since we know that in fact the presumption on which it was started, which is that low income Medicare beneficiaries cost more, is actually not empirically true. That was why I thought about this notion that we've talked about trying to do a better targeting of

severity of illness. That if we in fact can do that, I'd be much more inclined to make that not budget neutral and put more money than to put in --

DR. ROWE: Based on case mix index or something like that.

DR. WILENSKY: Exactly.

MR. ASHBY: Let me remind you of part of where we were last time around on this issue. We had posed the question of whether we saw as beneficial to have one formula that would apply to everyone. But one of the options that we discussed at the time was whether we should at least go to two formulas that would treat public hospitals different from privates since they do have public monies coming to them from state and local sources to help cover the cost of uncompensated care. Now we could revive that idea, pay for only three-quarters, or include only three-quarters of their uncompensated care or some other way of handling that to lessen this redistribution.

I'm wondering if you want to have us consider an option of two that would improve the shift that you speak

of.

DR. WILENSKY: Especially a shift that doesn't make sense for Medicare to be promoting.

MR. MacBAIN: Just on Jack's last comment. I'm not sure that we want to take a look at -- classify differently those hospitals that have other sources of funding for uncompensated care. I think by the same logic, you'd exclude private hospitals with large endowments. I'm not sure that the ownership of a hospital really should be the issue.

MR. ASHBY: Right, and that's kind of where we came down last time.

MR. MacBAIN: The question gets back to, is there any empirical evidence that this is a worthwhile program to begin with, and I think the more we analyze it, the more we're going to come back to that same question.

The other thing I wondered about but I think you answered it is, why under option two, if we're adding money to the system, to the private other teaching hospitals still come out with a negative? But it sounds when you were

describing it as two different pots --

DR. ROWE: Because that's a MedPAC rule.

[Laughter.]

MR. MacBAIN: Within the two pots they still lose.

MR. ASHBY: Right. Many of these are the suburban located and small urban located hospitals that are not in neighborhoods where they provide -- I mean, that was actually the intention of the redistribution is to not pay money to hospitals that don't treat the non-pay patients. That's where that's coming from.

DR. ROWE: So these are those private major teaching hospitals that don't serve poor populations is basically what you're saying.

DR. NEWHOUSE: The private other --

MR. ASHBY: He was talking about the other teaching, the very small teaching hospitals. Right, that's who they tend to be. But in the private major teaching category it's the same point. As you can see, even in option one, the reduction is fairly small, 4/10ths of a percent. But that does represent the fact that those

hospitals on average have a little less uncompensated care than others. That's basically what it's saying.

DR. KEMPER: We can obviously reconsider anything, but it strikes me none of these arguments is a new argument, and actually I don't think these numbers are particularly new from the earlier discussion.

MR. ASHBY: No.

DR. KEMPER: So I view this as a wrinkle on an earlier rather significant recommendation, and I don't think that those arguments have changed.

DR. WILENSKY: I don't recall, although I may just not have been paying attention, that this issue about the redistribution between the private hospitals and the public hospitals came up in --

MR. ASHBY: It absolutely did, yes. And we had a whole graph, as Jack remembered, that --

DR. WILENSKY: I do recall the graph and the issue and the discussion about the concentration, how much concentration we wanted in there.

MR. ASHBY: Right, because that affected the

private-public split.

DR. ROWE: Let me tell you have we got to this unintended consequence. It's the first item on the first slide. What that said was, this is how we're going to define the threshold. We want a larger proportion of the total number of hospitals, up to 60 percent maybe, because that will in fact capture more rurals. But then we decided to define the threshold by putting all uncompensated care, Medicaid, and Medicare with SSI eligibility. When we did that, the public hospitals that treated a relatively small number of Medicare patients fell into the mix because of their high proportions on the others. I think that's how we got here.

DR. WILENSKY: No, what we were doing was to take -- up until now it wasn't -- I think there's a discussion to be had about whether we want to have this go to the 40, 50, or 60 percent of the hospitals, however we want to do it. What we were doing is, in the law previously, the threshold that you had to meet in order to get any disproportionate share money was set higher for the rurals than the urbans,

which was totally unfair. One of the things that we were doing was to say, whatever threshold we set, it ought to be the same for urbans and rurals, which I strongly support.

That the definition of low income was peculiar. It missed a lot of low income. And by focusing on Medicaid, particularly when you have states like Tennessee that basically with TennCare do away with the distinction between uninsured, poor uninsured, and Medicaid, that also made no sense, so we had to have a broader definition. That was really how we got into it.

The rural problem that we were trying to respond to is that they were having to meet a higher threshold of need than urbans, which was just patently unfair.

DR. ROWE: Right, and we have corrected that.

DR. WILENSKY: But I think we're now seeing a result which to my mind is not a sensible use for Medicare monies. I'm perfectly happy to see what happens if we use 60 percent of the hospitals affected rather than 50. But I would also --

MR. SHEA: I'm not sure I'd agree categorically

with Gail's point, but I do think that the numbers here are significant. So I think we ought to look at the 60 percent and see what difference that is.

MR. ASHBY: Before we quit though we should take a look at the urban and rurals. We didn't get that far in Deborah's presentation.

MS. WALTER: This clearly shows the urban-rural dichotomy, and I think it's striking. Obviously, you see that it increases significantly, the percentage change in total PPS payments increases significantly within this group here. Obviously, all hospitals fare best under option two.

I'd also like to point out that by design in option two you see this zero. There's no change basically for the urbans under option two.

DR. ROWE: And the bottom here, PPS inpatient margins, that's percent change in them, right?

MS. WALTER: No, those are the PPS margins. Why we included that on there is because I think that this table is fairly striking in terms of what the options would do for the rural and small urbans. But when we actually look at

the margins, I think what these options will do would bring up the rural margins and you would achieve near comparability between the inpatient PPS margins by having these options, or by implementing one of these options.

So I guess we, again, just wanted to show that there is a striking difference between the large urbans and the small urbans and the rurals. But we have to consider that the margins have been very low, or comparatively lower for the rurals.

MR. SHEA: Deborah, just so I'm understanding this. The inpatient margins numbers are with the change or without?

MS. WALTER: They're the current existing margins.

MR. SHEA: So that the rural would change by?

MS. WALTER: It would bring up the rurals almost to near what the urbans are.

DR. WILENSKY: Current law.

MS. WALTER: If we were to change something.

DR. WILENSKY: These are all the problems, but this is the last data we have. These are where we're

starting from.

MS. WALTER: Right.

DR. WAKEFIELD: On the face of it, my initial reaction when I looked at this chart in our document was, because you're asking us which option to support, prior to all the rest of this discussion the option that I, of course, was most drawn to was option number two. But being a relatively number commissioner on this commission, this option number two, do we care about what's politically viable?

DR. WILENSKY: If you have a half-billion in your pocket.

DR. WAKEFIELD: Right. So much as I like option two, there's a bit of a concern there about how viable it is as a recommendation. So do we care about that? Does that ever affect MedPAC's --

MR. SHEA: It depends on the day.

[Laughter.]

DR. ROWE: The answer is, it depends.

DR. WILENSKY: Normally, we are cautious about

just adding more money into the pot. There are times where we have made, with regard to administrative budgets and indicating concern about last year in our report about the administrative budget of HCFA given its new responsibility. Normally, we do not make recommendations that have significant new spending without making at least some reference to --

DR. WAKEFIELD: I like option two listed in the document actually because I think it demonstrates the magnitude of this issue. So it helps make a point. But my question was just, when push comes to shove, how --

MR. ASHBY: Let me comment on that also. We thought of this partially in the context of the October issue, if you will, as we've been talking about. That is, first of all, if $500 million was not available then it could be done with $200 million and it just takes you part way. There's any number of options. And we thought that perhaps in the environment of Congress' willingness to put some additional money back into these payment systems that who's to say that the corrections we make have to be exactly

on doing provisions of the BBA. They could be different provisions that make sense.

So we thought in that context this might be an option, even if $500 million is too much. If it's too much, well --

DR. ROWE: Would it be fair for us -- I'm sensitive to Mary's question as well. Rather than our establishing policy that Congress would establish, would it be fair for us to make the arguments pro and con and then provide one budget neutral and one non-budget neutral proposal? That is, choose amongst the two budget neutral proposals you have here and say --

MR. ASHBY: Say, if you have additional money, this would be a viable way to --

DR. ROWE: -- if you're requiring budget neutrality with respect to this correction of traditional urban-rural problem, here is MedPAC's recommendation of how you do it. If additional resources are available in order to do this, here is MedPAC's recommendation of how you do it. Still then we would have the specifics of the 60

percent or whatever and then Congress or whoever it is who decides these things, could have some choices in their debate. That makes it a little cleaner for them I think. Does that make sense?

DR. WILENSKY: By the time you get this, whatever is going to happen, it's going to have happened. But I think when we do our March report or whenever we're going to have this number available, we can certainly indicate that there's an additional amount of money which will protect the losers and bring --

DR. ROWE: If they wanted to do that. And if they don't...

DR. WILENSKY: If they wanted to do that. But I don't think it really changes what I regard as the much bigger question.

DR. ROWE: This maldistribution.

DR. WILENSKY: Which is what seems to me an unintended consequence that we have -- I regard it as an unintended consequence of using Medicare money. So it may be that we just need to see what happens, as Jack says, as

we go and have 60 percent, or some other numbers to show what the distribution is. I would not have regarded the outcome that we have observed as one which we would have thought desirable for Medicare.

MR. MacBAIN: Again I'm not sure, at least from my perspective, whether public ownership of a hospital is the issue so much as redistribution to hospitals that have a disproportionately low share of Medicare business.

DR. WILENSKY: Exactly. I'm using that as --

MR. MacBAIN: Using public as a proxy. But I think we ought to be careful that we're not --

DR. NEWHOUSE: That really is inherent. I think you mean disproportionately high share of uncompensated care.

MR. MacBAIN: It's the low -- it's the bump in payment out of proportion to the size of the Medicare business. That's the issue.

DR. WILENSKY: That is what I'm speaking of.

MR. MacBAIN: I think we need to be careful about that so it doesn't sound like we're slamming public

hospital; we don't think that Medicare ought to be paying its fair share. But the issue is that it's --

DR. WILENSKY: That this is a Medicare program and these are hospitals that treat lower --

MR. MacBAIN: It's the extent of Medicare patients that the hospitals treat that's the concern.

MR. ASHBY: But do remember though that in this simulation and in our recommendation, the payment is only made on Medicare cases. So if they have few Medicare cases, they're going to get a small amount of payment.

DR. ROWE: Their percent increase seems greater, but the actual amount of dollars --

MR. ASHBY: Exactly, right. And that was a very purposeful part of the -- we considered the option of removing this from per-case payment and resoundingly said, no, it needs to stay that way so that it does reflect --

MR. MacBAIN: So on the prior graph that was up there, it looks like the private teaching hospitals are financing the public hospitals. When you get down to the dollar amounts it's not nearly as dramatic as the percentage

amounts, and that's important to keep in mind.

MR. ASHBY: No, that's not the case, right.

DR. ROWE: So 7 percent on that graph is not twice the amount of money that 3.5 percent is.

MR. ASHBY: No, it's just the change in the amount of money. They get 2 percent more than they would have otherwise, but they're starting from a much smaller pot. We can show some of those numbers, I think. That would put some perspective on this, if you will.

DR. KEMPER: That would be helpful.

DR. WILENSKY: That also I think would be very useful in addition to the 60 percent.

DR. LAVE: Could we also see the proportion of Medicare patients? Since we're looking at what we're doing both --

DR. ROWE: That would drive that other number.

DR. LAVE: I know, but both in terms of the total distribution of these dollars.

MR. ASHBY: Right. We normally express that as Medicare costs as a percentage and we can easily provide

that, too.

DR. MYERS: How hard would it be to look for those hospitals that are specifically affected, positively and negatively, by name?

MR. ASHBY: Let me answer that. We do have some information actually in the mailing materials that give you some information about magnitudes of change, but we can't do it by specific hospitals. That was our arrangement with the AHA, and I think it's a fair one, that we not -- they insisted we not publish that, but we weren't anxious to anyway really.

DR. LAVE: We have to decide what policy we like, not whether our friends or enemies are being negatively or positively impacted.

DR. WILENSKY: I think when we see the dollar magnitudes may well relieve some of the concern that the percentages that you show. Again, it is only my concern that these are Medicare dollars.

DR. ROWE: Between that and 60 percent you may get

the comfort zone that is defensible at least, because if this is the only number you see, it's hard to defend.

MS. WALTER: We do have some slides on the magnitude, but I think what I'm hearing is to come back next time with a 60 percent threshold.

DR. WILENSKY: But also give us these other numbers where --

MR. ASHBY: And this other information that provides some perspective on the whole thing.

DR. WILENSKY: It is hard to get a sense of perspective because the percentages are different, but the bases are even more different. When we're talking about redistributions that are counterintuitive it's especially important to see what that leaves us in terms of the distribution of this Medicare money.

MR. MacBAIN: I want to circle back before we get off this though to where we started which was this discussion of whether Massachusetts is unique and whether this is perhaps a solution in terms of a problem. Do we want to deal with that? Do we want to get into the policy

advisability of DSH in general?

DR. WILENSKY: If we were going to consider things like putting in a half-billion dollars to bring rurals up to parity, I really would like to take this other issue which strikes me as being a much more legitimate Medicare issue of saying, if we were going to consider being able to define severity of illness in a more appropriate way, which has been a long term Medicare problem, and to add money rather than to redistribute among the existing the redistributions. I would like to see us take it in a broader context of what is it we're trying to do.

Now whether or not we're going to go into areas that Congress really wants to hear from us or not -- I mean, I think it would be sort of the second half of a chapter, or the last third of a chapter that says, there are empirical reasons why you might want to rethink what it is that you are doing with these funds, given that there does not appear to be an empirical relationship between the cost of treating low income seniors that we assumed when the program was put together.

MR. MacBAIN: Something that would be useful for me at any rate is if staff could give us an outline of all of the special Medicare payment provisions for safety net providers; critical access hospitals, federally-qualified health centers, rural health centers, sole community hospitals, rural referral centers. Just go down the whole list so we have a sense of what is happening out there now.

DR. LAVE: I think that the idea of coming back and thinking through what it is that we thought we were doing is a reasonable one, and certainly Bill's recommendation is useful for that. Because if I remember the previous discussion which I think Peter was referring to, we basically thought about it as giving more money to those hospitals who had more people who did not pay their bills. So it was a very explicit recommendation that --

MR. ASHBY: Related to access to care is the terms that we were putting it in.

DR. LAVE: It was an access to care issue. It was not a severity of care issue. So I think that if we decide to go back to the severity of care issue that really is --

MR. ASHBY: A different adjustment.

DR. LAVE: A very different framework and so forth.

DR. WILENSKY: The only thing though is, it's supposed to be, I would presume, access to care for Medicare seniors. What I'm not sure is that what we're doing is responding to an access problem for low income seniors that exists. That's why to the extent that we are not in fact appropriately taking account of severity measures, you can say that that is much more likely to affect access for those institutions that are treating systematically sicker Medicare patients.

I don't have any problem having this as a broader discussion, what are we trying to accomplish? But it ought to be, it seems to me, in the context consistent with the position we've taken elsewhere that we're trying to use Medicare monies to benefit seniors, and if there's an access problem we want to be sure that it's an access for seniors problem, not just a general access problem.

DR. LAVE: We don't have any data, Gail, that

shows that seniors that -- I don't believe that our data in rural hospitals indicates that they have access problems. So I agree with you that we have a problem.

DR. WILENSKY: But we don't have any data that suggests these hospitals, that low income seniors are having access problems either.

MR. MacBAIN: If we use a 50, or let's say a 60 percent threshold, the implication is that 60 percent of the hospitals participating in the system are at risk and need to be shored up in order to maintain access, and think that's true.

DR. WILENSKY: That's certainly not true.

MR. MacBAIN: But a number are at risk.

DR. WILENSKY: That's just not true.

MR. MacBAIN: So maybe we should be -- is there a way to focus on that? If the question is access rather than severity, then should we be focusing on those hospitals and other providers who are at risk? I don't know. I think it's worthwhile getting into that discussion, getting over the current DSH policy into a broader discussion.

DR. WILENSKY: I think that we would like to see these additional numbers and also, to the extent that you can at least lay out some of the questions that you've heard us raise here to try to ask us again, do we want to go down this path, which is not questioning the fundamental assumption of the program -- in the past we have not questioned the fundamental assumption of the program. We just sort of rolled with it, so whether or not we want to step back and put it in a better context. And we may or may not choose to do that.

MS. WALTER: Do you want us to focus on all three options again, or do you want us to just limit the analysis at the 60 percent threshold in options one or two?

DR. WILENSKY: I guess at this point it's running another table?

MS. WALTER: It's easy enough to do.

DR. LAVE: I can't see the advantage of option three. Does anybody else see an advantage?

DR. NEWHOUSE: I don't see an advantage.

DR. WILENSKY: So just one and two?

DR. LAVE: I would just focus on option two since option three seems to make things worse.

MS. WALTER: Okay.

MR. ASHBY: Kind of our thinking, too.

MS. WALTER: Yes, that was sort of our summary.

DR. WILENSKY: Thank you. Judy?

MS. XANTHOPOULOS: We're going to talk about a possible workplan for the methods used to construct the hospital outpatient payment rates. But first I'd like to go back and review the two recommendations that were made in the March '99 report, the two relevant to the payment rates.

We recommended that they define the unit of payment as the individual services and then use costs of individual services, not groups of services, to calculate relative weights. Unfortunately, no one responded to these recommendations so we are faced with the system of APC groupings right now that's in the proposed rule.

So in that light, it looks as if HCFA, all indications are that HCFA intends to go forward with the APC grouping in this rule. So we're basing our work on three --

we've identified three unresolved issues within this system.

The first one is the possible phase-in of the PPS rather than direct implementation. We just wanted to make the point that this is something that staff is currently working on. It's a live issue. We've provided technical assistance to the Hill on basically two options; a budget neutral phase-in and a non-budget neutral phase-in.

The single update mechanism for OPDs and ASCs was presented in last month's meeting and we're continuing work on that.

The third area that we think is a potential area for some work is to look at the design of the APC and the methods used to construct the weights, the payment rates.

The one thing we want to acknowledge is that we are not saying that we think that APCs are necessarily the best system to go with, but we're basing our work now on the notion that this is what we'll be facing, so are there ways that we can improve it and make for better payments or more accurate payments?

The one issue that has been a recurring theme in a

lot of the comment letters that HCFA received -- and they did receive 11,500 on this proposed rules. It was a pretty good response to the rule.

DR. LAVE: Did anybody like it?

MS. XANTHOPOULOS: No, actually no one did. We actually reviewed a lot of the letters and one technical issue that kept recurring was the issue of the use of single procedure claims as opposed to multiple and single procedure claims. So we started to investigate this issue.

There are certain groups that seemed to be hit harder with the proposed payment rates than others, but a lot of it we think may depend upon how they calculated the weighted median costs. They started with 98 million final action claims for 1996 and ended up -- the procedure of eliminating claims ended up with 26 million single procedure claims.

I might say that in defense of HCFA, they did have a reason for going down to -- using only the single procedure claims, and that reason was that when you have a multiple procedure claims you have certain fixed costs that

you can't allocate accurately to each procedure. So they felt that this was an easier way was to go just with the single procedure and then you have the cost like anesthesia or recovery room that could be directly allocated to the procedure.

DR. LAVE: Can you tell me what a single procedure claim is?

MS. XANTHOPOULOS: It just means that someone who came into a outpatient department only received one service. A multiple procedure means that you had more than one procedure performed on the patient for that event. And they do define the episode as the event going in. So if you come back the next day for something else, that's considered a separate procedure.

DR. ROWE: But procedures would include like blood tests and chest x-rays and cardiograms and whole variety of things, right?

MS. XANTHOPOULOS: But the way they're paid now is based on costs so they're identified -- what we're talking about with the procedure and the ancillary costs are things

that are not necessarily billed separately, like time in a recovery room or some other aspect that's not an identifiable service. The services themselves can be billed separately, and with a variety of systems, as you know, under the present law.

So what we started to do was to investigate the payment calculation. It looks as if, just from the beginning analysis that I've done, I've done a sample -- it wasn't a random sample. I actually chose a lot of the APC groups that were recurring in the comment letters, and people that have come to speak with us about it. So I looked at a lot of the ones where there's specifically blood product groups and cancer hospitals, as well as certain radiographic procedures. I looked at those, and then tried to go across a variety of groups and randomly select a few others.

It looks as if using multiple procedure claims may actually change the weights that were needed to calculate the median cost. I think that there may also be a bias in the median cost by actually adding more observations.

DR. LAVE: What direction was the bias?

MS. XANTHOPOULOS: In the sample that I looked at it was a downward bias in the costs, which I think that it's not clear how it will work when you look at all 500 APCs. You may actually see some that are biased upward and others that are -- but it looks as if, looking at the multiple procedure claims it looks as if there was more frequency in the more expensive procedures on multiple procedure claims. So that's something that we would like to investigate.

Our workplan basically has three parts to it. We wanted to determine the relative proportion of multiple procedure claims to single procedure claims. We wanted to estimate weighted median costs, and simulate payment rates using both different types of procedures; do it once for single procedures and then again including the multiple and single procedure claims.

That's basically it. It's a pretty straightforward approach. We think that it does offer the ability to look at other issues, in particular maybe looking at the APC groups. But as we said, it looks as if that's

something that HCFA is going to go forward with. They've invested almost 10 years in developing the system, so it doesn't look as if they'll get rid of that, they'll eliminate that system.

DR. LAVE: So you'll use their grouping system, you'll put the stuff through the grouping system and you're really looking to see whether or not if you use different kinds of data you arrive at a different payment rate?

MS. XANTHOPOULOS: Right. And as I said, thus far it looks as if that is the case.

DR. NEWHOUSE: Suggestions for Judy on the workplan?

DR. WAKEFIELD: A question. With regard to the possible phase-in of the PPS, given that I think it's HCFA data that indicates that over one-third of rural hospitals are low volume providers and they estimate that those rural low volume providers will face payment declines that are -- their data -- on average, four times greater than all hospitals. Should there be some consideration for adjustments for single low volume providers in rural areas

that could account for the fact that they've got fixed costs, that are spread over a low volume service resulting in higher costs per visit?

MS. XANTHOPOULOS: One of the things we were talking about that wasn't really -- we view this as basically the first step of examining the payment rates because once you determine whether there is bias then you can allocate them to different hospitals in different areas and see what impact that has on the payments.

I think that the preliminary look at the data, there's a very high concentration of services in outpatient -- of the services delivered in an outpatient setting. So even though there are several hundred thousand that are approved services, they're not -- the most common make up the bulk of the payments, and it varies across settings. So that's something that we could probably --

DR. WAKEFIELD: We'll be able to take a look at this by setting, too?

MS. XANTHOPOULOS: Right.

DR. NEWHOUSE: Mary, that's opening up a very

large issue. The same issue arises for hospital inpatient, the same issue arises for physician, it arises throughout the whole payment structure. And as far as I know, in all of the PPS systems we've basically ignored economies of scale. Now that's not to say we should have ignored them, but we do.

I would have thought that if -- maybe I'm just being too Cartesian, but if we opened it up for hospital outpatient, we would have to open it up for the others as well.

MS. XANTHOPOULOS: I guess there's a little bit of a hybrid of an issue related to this in that looking at where procedures are performed as opposed to volume. That's something that some hospitals have a very limited number of procedures that are -- or the most common procedures that are performed in that hospital. We may be able to look at something like that, but not necessarily address the volume issue, but look at the types of procedures that are done and the effect that that would have.

DR. WAKEFIELD: Do you think you'll be able to cut

the data so that we can look at this by category, at the very least by rural hospital?

MS. XANTHOPOULOS: Yes, we have it at a hospital level.

DR. WAKEFIELD: For starters then is what you're saying.

MS. XANTHOPOULOS: Yes.

DR. NEWHOUSE: Indeed, the margins that we saw in the previous presentation could potentially relate to economies of scale.

DR. WAKEFIELD: To this, too.

DR. NEWHOUSE: It may relate to other things too, but consistent with economies of scale.

Other reactions on the workplan?

Shall we take silence as applying blessing of the workplan?

MS. XANTHOPOULOS: Should we go ahead and proceed?

DR. NEWHOUSE: Yes.

Janet and Julian?

MS. GOLDBERG: As part of our workplan related to

payments to teaching hospitals we evaluated the literature to determine whether teaching hospitals provide higher quality care. The evidence that we found of higher clinical quality led us to investigate what indicators might be used to measure enhanced patient care.

We based our review of the evidence and our assessment of potential indicators of enhanced patient care on the assumption that enhanced patient care leads to higher quality and higher costs, and that higher quality warrants higher Medicare payments. The literature alludes to a connection between enhanced patient care and quality, but doesn't prove that enhanced patient care leads to improved quality.

Most of the literature that compares quality among hospitals relies on clinical measures because it can be difficult to find and consistently explain relationships between hospital structure and the care that clinicians provide. Studies involving clinical measures of quality suggest that major teaching hospitals provide higher quality care compared with non-teaching hospitals.

These studies evaluated the quality of care provided to Medicare beneficiaries with specific diseases. Data for these studies can from either individual patient chart reviews, Medicare claims data, or both. It's important to keep in mind that not all teaching hospitals provide increased quality to the same extent.

Ideally, we would like to measure quality of care and determine how to adjust payments accordingly. Unfortunately, there is currently no comprehensive national database which would enable the routine assessment of clinical quality in hospitals. Therefore, the Commission may want to consider the merits of using proxy measures to evaluate enhanced patient care until direct measurement of quality is possible at the national level.

In the short term, therefore, our options for proxy measures are limited to those for which we have data. This includes the resident to bed ratio and transfers into hospitals. In the medium term, the Commission may want to consider exploring other proxy measures that have merit but would take some time to develop.

We gathered information on several potential proxy measures. These included the use of technology-intensive services and procedures performed primarily at teaching hospitals, care for patients with rare and complex conditions or who are severely ill, the scope of a hospital's biomedical research portfolio, the mix and quantity of clinical staff, and transfers into hospitals.

We also thought about several criteria that might be used to ascertain whether or not a potential proxy measure has merit. In order for a measure to be useful, we must have reliable data. There should also be a solid rationale for the relationship between the proxy measure and quality. In addition, the measure should be strongly associated with quality pertaining to all hospitals, not just teaching hospitals, and minimize undesirable incentives.

Transfers of patients into hospitals appears to be a promising proxy measure for several reasons. First and most importantly, discharge records provide a readily available, reliable source of data on patient transfers into

hospitals. Second, several studies indicate that patients transferring into hospitals are sicker.

Third, the transferring of patients is strongly associated with quality, since transfer patients tend to be sicker, they tend to require technologically superior care, specialized services, and superior clinical expertise. Fourth, the transferring of patients can be measured for all hospitals, not just teaching hospitals.

However, it may not be desirable to use this as a proxy measure. For instance, it's not clear how hospitals will respond to the use of transferring as a proxy measure for enhanced patient care.

I'm looking forward to getting Commission feedback on whether or not to continue our investigation of proxy measures for enhanced patient care and which measures to focus on. Also, it's possible that the document that we sent you in preparation for the meeting will be included as an appendix to the March report, so if you have any comments, I'd appreciate any comments that you'd like to share.

DR. NEWHOUSE: I guess I'd be very concerned about basing payments off of transfers -- moving to that as just national policy. If somebody wanted to try this in a small area to see what it induced in the way of changes in transfers, that would seem to be reasonable. But I hesitate to put incentives, monetary incentives in the system to transfer. One could have a transfer from one non-teaching hospital to another so everybody just gets cross-shipped.

I had brought up, and I thought a number of other people liked the idea a long time ago and it seems to have been dropped, the notion of expanding the number of DRGs. Now we may not have the resources to try to undertake what amounts to building a new --

DR. WILENSKY: Severity of illness.

DR. NEWHOUSE: The severity of illness is one variant of it that's a sort of off-the-shelf variant. But one could go back to the drawing board and instead of starting with the constraint that there only be 500 DRGs, start with a much higher number.

MR. PETTENGILL: There's 1,420 in the APR-DRGs.

DR. NEWHOUSE: I know. But as I understand it, those are nested within the current DRGs.

MR. PETTENGILL: In a manner of speaking, yes.

DR. NEWHOUSE: So there's no particular -- I mean, I think the people that were developing that took that as -- what I'm suggesting is that we might see if HCFA is more amenable than it's been in the past to removing this constraint, which is not in statute, I don't believe. Or if we might think about contracting, if we can't do it internally. That is, I'm not persuaded that the enhanced DRGs -- they'll be better, but that that's -- whether we're on the flat of the curve or not, I don't know. I don't think we can know until we try to do it.

I'll put that out there and see how other people react to it.

DR. ROWE: I'm not sure -- I think on the surface of it, the transfer idea looks appealing because presumably you're only transferring a patient from hospital A to hospital B because hospital B has something more to offer than hospital A, and I guess that's enhanced patient care.

But I agree with Joe, I think that the potential for gaming of this system would be great, and I think there would be inequities based on the different systems that are being developed.

If you have a teaching hospital that owns a number of community hospitals, like say 10 community hospitals around Cleveland, just to pick a random example. And if all those doctors are employees, which they might not be. But if they were, then you can direct the referrals without getting in trouble with the Medicare Fraud and Abuse Act and stuff like this. Whereas in a traditional teaching hospital that doesn't have a network of hospitals that it owns, you rely on professionally-based, experience-based referral patterns.

So you could have gaming of this system based on the structure of the Intermountain Health Care system versus X system. This would create confusion and I think it would probably not work. So I would be concerned about that. I think you have a change in the structure of the marketplace which would aggravate the change that Joe commented on.

I think it would be interesting to look at some data, if you have any, as you do the analysis on grades of teaching hospitals. I think you're using the traditional definition of a teaching hospital that has a resident to bed ratio over 0.25 or something along those lines, which gives you 1,200 teaching hospitals or something like that.

When you start to do these analyses you might look at different resident to bed ratios to see whether or not it makes a difference in terms of the outcomes. I think that that would be a robust way to look at the data because there is no mutually agreed upon definition of a major teaching hospital, or a teaching hospital for that matter, other than one that has three RRC-approved residencies. That's what you basically need. You can't have any unless you have at least three.

So I think that the range of resident to bed ratios is very great and there are plenty of hospitals in each part of the range, so that would be worth doing.

DR. MYERS: As you continue this analysis, I think you also want to explore the concepts surrounding

appropriateness of care that really aren't talked about extensively in here. As you know, the mere presence of technology and the skill to use it is not the complete story. It's whether you're using it with the right indications, whether the medical necessity is there. I think that if you look at some of the work that was in the President's quality commission, there was a lot of discussion of appropriateness. There was a lot of discussion of the concepts surrounding overuse.

I'm not exactly sure how you would create national factors at this point to bring that in, but I think it's worth thinking about as we move forward in this area, because it is a major consideration. A lot of people who have very skilled people in my opinion and who have the technology available, don't use it appropriately.

MR. MacBAIN: In looking for a proxy, or several, as least as I read through this thing it seemed to me that we may want to be a little more rigorous in how we define enhanced patient care. In some of the stuff we've written it's been used interchangeably, and other times with

severity or complexity of patient services, sometimes in terms of the uniqueness of services that aren't available elsewhere. I think all of those are true, and we really need to look at all of them.

Expanding the DRG list may deal with complexity and severity but doesn't get to uniqueness of services or underlying quality. Transfer rates may be a proxy for quality in uniqueness of services but lose some of the DRG data. So I think you've got a more complex thing that we're trying to measure than we're giving it credit for being. I think we need to be more rigorous in describing it.

DR. NEWHOUSE: -- most felicitous to try to encompass all those three either.

MR. MacBAIN: The "E" stands for epiphany rather than enhanced.

DR. NEWHOUSE: We won't ask what PC stands for.

DR. KEMPER: I'd like to suggest that we amend the statement, you get what you pay for to, you get what you pay on. I think the transfer example is a good one. I guess that takes me to think about more of an index of multiple

proxies, just to diminish the incentives, and whether that might be possible.

Some of the potential ones that you raised in your paper and on one of the slides seemed like they might be feasible to me. From Medicare claims couldn't you get treatment of rare diseases and some of those things from Medicare records? You could get burn units and other kinds of special facilities. So I wondered if the data really aren't available on some of these things.

MR. PETTENGILL: In many cases, there are some data available, limited data.

DR. KEMPER: But not across all hospitals?

MR. PETTENGILL: Not across all hospitals and certainly not from Medicare records. There's information about facilities that hospitals have in the AHA annual survey, but that's not for all hospitals, and in many cases the definitions are relatively crude. It takes the survey some time to catch up with the newest facilities out there.

So it's not to say it's not usable. I don't know how much we can do between now and January which is when we

have to have everything done for the March report. All of these suggestions are good for a more intermediate term, further pursuant of the subject and I think we will no doubt take up your invitation to bring this back and get more detailed reaction on some of these suggestions. Like what is it you'd like to see if we went after rare diseases? Or if we went after expanding the DRGs, what in particular do you have in mind? That would be helpful to us.

But I think in the short run we're very limited in what we can do.

DR. KEMPER: I think the issue will be around for a while.

MR. PETTENGILL: I suspect it will, too.

DR. KEMPER: I'd like to see how they're correlated, even if they're imperfect measures at this point and not available for all hospitals, to see how correlated these various indicators are, because that would make it more possible to have an indexed kind of approach.

I guess the only other thing to think about on some of these measures if whether a high concentration of

Medicare risk or Medicare+Choice plans in the market would affect the measures, if any of them might not be available disproportionately in some markets than others.

DR. LAVE: I want to put another nail in the coffin of the transfer issue. There are lots of transfers which are not necessarily very sick patients, for instance, AMI patients in rural hospitals get transferred in. They're not all that sick patients. They're a high proportion of transfer patients because they're being transferred from a place that doesn't have the technology to treat to a place that has the technology to treat. So you're going to be picking up a lot of those and those are not the same kind of transfer cases as some of the medical --

DR. ROWE: But isn't that enhanced patient care?

DR. LAVE: But they can go -- I can tell you I've looked at this in the Pittsburgh area. They go to about three or four hospitals. They get transferred in. And one of the major bypass surgery transfer hospitals is not a teaching hospital, it just happens to be extraordinarily good at doing bypass surgery.

DR. NEWHOUSE: Or have a cath unit.

DR. LAVE: I don't know how many other cases of that there are of things like hip fractures. There's a lot of transfer that goes on that is not the sort of unstable sick.

DR. ROWE: Let me respond, if I may. I think this is relevant. I think this is the crucial concern. The crucial concern is that if we are changing GME for the epiphanous reasons which have been well-described here and elsewhere, and we are saying we're going to put the money -- but we're going to keep the money there because these institutions provide enhanced patient care, other institutions will stand up and say, but we provide enhanced patient care.

DR. LEWERS: All of them.

DR. ROWE: All hospitals will. And we are not teaching hospitals. Just like you said, yes, but they're not teaching hospitals. But if it's enhanced patient care it doesn't matter if they're teaching hospitals or not. So then the whole universe of hospitals will migrate in. The

individuals who are weighing against rather than for Professor Newhouse's epiphany are, I think, primarily concerned about that effect.

Now we may say, that's okay, we only want to pay for patient care services and we'll pay more for good ones regardless of whether it's a teaching hospital or not, and that may be where we come out. But I do think it's worth underlining the importance of this issue, as has come out in this question.

DR. LAVE: Now I did have another suggestion and that, again, is not related to the enhanced patient care issue in teaching hospitals specifically but it does come back to a way, I think, of looking at what some of the implications would be for the hospitals that are, to some extent, a matter of concern. And that is trying to see what the implications would be of shifting from a DRG-based payment system to shifting to an APR-DRG payment system.

My suggestion is the following.

DR. NEWHOUSE: I thought that was on the workplan.

MR. PETTENGILL: It is.

DR. LAVE: There are a number of problems that one would have in doing that. But, Julian, I think that you can get a set of -- one of it has to do with is the delay the problem of creating the weights? And if the delay is the problem in creating the weights, there are payment systems out there that have the weights associated with this. Now the relative weights may vary a little bit for Medicare than for all payers, but at least you would get some idea about what it would look like if you --

MR. PETTENGILL: We're generating the weights next week.

DR. LAVE: But I thought you said you couldn't do it by January.

MR. PETTENGILL: Oh, no. We can do that part.

DR. LAVE: I'm sorry, I misunderstood what you said.

MR. PETTENGILL: What I don't think we can do between now and January is pull together diverse sets of data to develop a whole set of proxy measures to look at. We don't have the time to do that.

DR. LAVE: But you will be able by January to look at the implications of shifting from one DRG-based system to another DRG-based system?

MR. PETTENGILL: Yes, absolutely. Long before January. I hope to give you some of that in November.

DR. LAVE: In doing that, will you reestimate the IME payment as you're doing that so we can get some sort of sense for what the differences are in terms of -- I mean, it seems to me that there were three things that we were thinking of doing, one of which was to basically revise our estimate of a teaching adjustment by using information based on interns and residents, whether this is correct or not, but pulling together the direct and the indirect costs. And knowing that that doesn't measure this enhanced patient care but it is something that we talked about doing.

So by January you're going -- what?

MR. PETTENGILL: There's two stages to this. In the first stage there are two parts, and they run in parallel. One of them is a reexamination of a cost function, folding in direct GME, reestimating IME, trying

alternative measures including proxies to the extent that we have them for enhanced patient care.

The parallel stage to that is developing relative weights and case mix index values based on the DRG refinement options that we discussed last time. We will present, we hope, quite a bit of preliminary results on both of those in November. Then because they're interactive, we will pull the interactions together and present results on the impact on payments to hospitals of adopting different options where we'll fold in the revised IME estimates, we'll alter the payment model to reflect the inclusion of GME, and so forth and so on.

DR. LAVE: Okay, because that wasn't in here. I just didn't have a sense that that was going on.

MR. PETTENGILL: No, all this was about really was, do we have any evidence that teaching hospitals provide higher quality care because most of the so-called -- most of the things that you might imagine are enhancements in patient care, most of the things that commissioners have discussed as such are things that you really would only

value and be willing to pay more money for if they resulted in some difference in the quality of care. So is there evidence that teaching hospitals provide enhanced care.

And second, what kinds of measures could we use to represent that? As Janet said, ideally we'd love to be able to use clinical measures of quality of care, but there's no way in the world that's going to happen any time soon. So what do we use instead?

DR. LAVE: No, I at least was kind of misled by this chapter in terms of the direction of where you were going, not realizing all this other stuff was going on at the same time.

MR. PETTENGILL: This is just a small piece of the larger project.

DR. WAKEFIELD: Just a couple comments. Actually, I agree with Woody, and Woody, I served on that commission on quality that you just referenced. I think that part of the way this document defines enhanced patient care, quality care is really in a significant way -- this may be just my view -- is really to say, good care for Medicare

beneficiaries in this context is high tech, biomedical research-based care.

Based on my experience working in different venues on quality related issues I'd say that in general there are other issues that can't be captured probably, but that there certainly are other very valuable components when one looks at quality of patient care and tries to link that to something we refer to as enhanced patient care, like systems in place that reduce error, for example. An important issue. Like patient satisfaction.

It was interesting to me that the Picker Institute study that talks about the one exception to non-teaching versus teaching hospitals -- and I don't want to much go there except to say, that one exception -- it talks a little bit more to some of the psychosocial variables as opposed to just basic biomedical issues -- is relegated to a footnote and not explored further or delineated with more definition in the text of the paper.

So point being that things like orientation toward good discharge planning, patient education, beyond just what

we've identified as proxies for quality care, to me there's a bigger, broader picture out there that, if we're going to say this relates to quality care, I just don't know how we can do it with this fairly narrow view, either short term, or maybe this is all we've got and can focus on in short term, but over the long term -- certainly over the long term I don't know how we can do it.

To me it's more of a -- rather than enhanced patient care it's an intensive patient care because it speaks to high tech interventions, et cetera. And back to Woody's point, I'm a little bit concerned about that. As we know, you can have overutilization of high tech interventions that may not be good at all for patients. So that's one set of issues for me when I finished reading this.

Another set of issues that -- gosh, you've heard it from me before. It's just back to those other two categories of looking at outpatient, both primary care training and enhanced patient care in outpatient facilities. I hear your concerns about the difficulties in trying to

find measurement, ways to measure what's going on if we're going to try and quantify enhanced patient care. In that environment I'd say we've still got some difficulties, at least using my definition of quality, defining enhanced patient care in inpatient settings as well based on my comments a minute ago.

But that outpatient setting is still a real concern for me. It's been a long time since I looked at it, but I think it was one of the issues we were asked to look at by Congress as well as the non-physician provider piece, and that too would be an issue both in inpatient as well as outpatient care. I'll give you a copy, Julian, of what I think is a good article on the outpatient side that looks at non-physician providers that might be worth looking at in the total scheme of things.

But this issue, this document right now doesn't even speak to the potential for putting on the table something of a framework for looking at outpatient primary care, that we don't even put a marker in here right now for the March report, and that concerns me as I mentioned at our

last meeting.

DR. NEWHOUSE: Let me try to summarize since we're past noon. I think Julian framed it correctly when he said, we know this set of hospitals that we have called teaching hospitals costs more, and we have said that we think those extra costs are buying some kind of different -- they represent -- he asked, what are we getting for those extra costs? That's the question. We should be getting something, if we want to pay for them.

Bill went back to our earlier discussion and identified three possible reasons for those costs. I think we shouldn't get too trapped in our wording of enhanced patient care. One was severity or unmeasured case mix, and that's what breaking apart the DRG system into finer categories potentially goes to, and the unique services.

Then a third reason is just basically even for a given patient that's the same, the patient may be treated differently in a teaching venue, and what I took the burden of the chapter here to say, to the degree that's the case, what can one say about the value of that difference in,

shall I say, the style of care for a given patient? And that the literature then supports that we're getting something of value for the extra money.

All that leads us to, what do we do about the payment system, and the proxy measure? What we haven't really emphasized in this discussion but I think everybody understands is that we would like to get rid of, or minimize the distortion of paying on the number of residents and the distortion that we think has caused more residents to be in the system than were there before. Peter talks about maybe we could have many proxies and that would lessen the weight that goes on the number of residents, and therefore, there might be fewer residents.

To the degree that there's many proxies, we have many small distortions presumably instead of one larger distortion. That could give incentives all up and down the line on each of the measures we've put in. I should say even the expanded DRGs are vulnerable to this. We presumably will have one-time coding changes. Every time we tinker with the system we get coding changes. Those could

be potentially recouped downstream by adjusting the update factor as in fact has happened in the past. But there will be some cost there as well.

We may want to still continue to think about whether we want to call it enhanced patient care. I kind of hate to get trapped by our language. But I think that's where we're at. I think this chapter, I think we're actually on the right path here with where this has been going.

MR. PETTENGILL: If I can respond to that. I think the way I would react to the discussion here would be to say, there's very little that we can do in the short run to answer this question. It's obviously a very complicated question. In fact, we spend a lot of our time as a commission talking about quality of care, and access to care, and appropriateness of care, and that sort of thing. That's a whole research agenda all by itself.

So what I would suggest that we do is expand this a bit, to lay out the set of questions that need to be answered in order to get a better handle on proxy measures

for enhanced patient care, and to take into account that the questions are not only about inpatient care. In fact, the more important questions may be about ambulatory care; that is, the ones that are harder to deal with. And that's what we would do for the March report.

Then on a longer term basis we can begin to dig into some of these issues, drawing on what the benefit of what other people on the staff are doing vis-a-vis quality of care. Does that sound like a reasonable proposal?

DR. LOOP: I'm still somewhat skeptical that you can actually quantify or qualify enhanced patient care. I'm not sure we've really defined what enhanced means. It's somewhat quality, value, all those things. But what you're really trying to measure is experience, coordination, coverage, depth of care. Those are very hard to measure.

One thing you might try to do, along with transfers and the case mix index, is intensive care unit beds. I don't know that you'll find anything there, but you might find that teaching hospitals have more and that's why they receive more transfers.

One thing you might do is to forget about trying to verify enhanced and just call enhanced care the incorporation of teaching programs, and that's the definition. That a residency program is a given for enhanced patient care because teaching is a public good. It's something to think about.

MR. PETTENGILL: That's the default. That's where we are now. And you may be right, we may not be able to --

DR. LOOP: But all the other things, that we've talked about here, particularly transfers, that will initiate a whole bunch of behavioral changes and I don't think that will work at all. I don't know any other -- there's not enough good outcome data to really verify that teaching hospitals have higher quality care. The risk adjustment is a little more sporadic and it's product line risk adjustment, but it's not well-published or well-adopted.

So I applaud your efforts. I'm really interested to see where it comes out on the APR-DRGs.

MR. PETTENGILL: So am I.

DR. LOOP: Because in just our own system I can't really see how you can differentiate the medium-sized teaching hospitals from the non-teaching hospitals. The big institutions I think you could probably see a big difference. But that alone will initiate some coding behavioral changes. I'll have to be educated about that as it goes forward.

MR. PETTENGILL: It's the coding changes, the potential for coding changes and their impact on the CMI and on payments that has inhibited the Health Care Financing Administration from adopting enhancements to the DRGs in the past. There is a way to deal with that, but they do not now have the statutory authority to use it.

It's not like they haven't gone through changes in the DRG definitions in the past and don't have some sense of how much coding change that leads to. You can make a forecast about what the coding change will be, and then you can make a forecast error correction two years later when you know what it was. They have the data to do it. They have the data that is collected through -- I forget what

they're called. The acronym is CDAC. They're data abstraction centers --

DR. NEWHOUSE: Clinical data abstraction centers.

MR. PETTENGILL: Clinical data abstraction centers which reabstract 30,000 records a year. That's enough data to get a pretty good estimate of what the coding change is. That data goes back to probably '95.

MR. ASHBY: Can I interject here for a moment that we are obtaining the CDAC data. It's already in the works.

MR. PETTENGILL: For a different purpose, yes.

MR. ASHBY: Yes, for a different purpose, but the data would be there if we chose to --

DR. LOOP: Just one other point, and just keep this in the background. As we're tinkering with graduate medical education, you have to also factor in the cost of medical education today compared to even where it was 10 years ago. The time that residents spend in training, the changes in graduate medical education, the declining reimbursements for hospitals and physicians, and the move to outpatient training. All of those factor in to whatever

you're going to do to GME, and we have to not ruin graduate medical education in the process.

MR. MacBAIN: As I keep trying to visualize how the new system would work it seems to me that we're talking about something that's an exception to the general principle that we've had that we ought to pay the same for the same service across settings. We're saying that there's something about a teaching setting. I'm consciously not using the term teaching hospital because I agree with the provision of the BBA that would look beyond traditional hospitals as a teaching site. But that there is something about a teaching setting, a teaching provider that merits a different kind of payment.

If that's where we're going, then the questions are, first of all, how do we define a teaching provider? I know one when I see one but I'm not sure I can define it. Except that it's a teaching facility only if people are there being taught. So the presence of students, residents, I don't think we can escape that at some point. That's what we're really trying to define, is something that as a

facility has an organized process of training future practitioners. So somehow we've got to incorporate that.

If we want to avoid encouraging adding more residents, adding more students of other medical professions, then the number may not be the critical variable, but the presence of students is. Maybe the thing we want to measure is the number of different teaching programs, different residency programs, other types of teaching programs. Whatever it is, I don't think we can -- if we're going to talk about teaching hospitals we can't get away from the fact that you can't be teaching unless you've got students.

The other question then is, if we have a way of defining this thing so that this institution now is authorized to attach some sort of modifier to every bill that it sends HCFA that results in a bump in its payment, is how do we calculate what the bump is? Is it a fixed amount across all facilities? Is it a percentage add-on? Does the percentage or the amount change given the dimensions of the teaching program? And if so, what dimensions do we measure?

DR. NEWHOUSE: Bill, we know there's this class of hospitals that have residents that have higher costs. We don't know to what degree those higher costs are causally related to the presence of residents.

MR. MacBAIN: But the presence of residents is the defining -- the thing that says, this is a teaching hospital.

DR. NEWHOUSE: We just know that there are this class of institutions where there are residents that have higher costs.

DR. ROWE: There may be other definitions, and that's what we're seeking, because this is the default option that Floyd mentioned.

MR. PETTENGILL: That's where we are.

MR. MacBAIN: The problem with the default is that if we use the number of residents, if we make the payment directly proportional to the number of residents, we've created an incentive to have more residents.

DR. NEWHOUSE: That's what we've done.

MR. MacBAIN: Where it's the presence of

residents, not the number of residents that may be more significant.

DR. WILENSKY: Right. Or not necessarily a linear relationship.

DR. ROWE: We're uncomfortable with residents because of the conceptual offerings that Joe has developed about teaching. We'd like to find another measure, and I guess we're not real happy with using the U.S. News and World Report ratings.

DR. WILENSKY: But it's also the issue, even more importantly, is what we're not happy with using the number of residents. Whether or not you use the presence of residents as part of -- Peter's comment about an index, I think is a very good one and having perhaps as a necessary component the presence of residents. But the question of --

DR. ROWE: I think the one thing I'm attracted to in this discussion is the concept of a multifactorial measure that might to some degree decrease the impact, or dilute the impact of specific gaming activities on the part of one organization so we don't get these absurd results.

And that's going to take a little longer, Julian, is what I'm hearing you say. I'm not seeking approaches to make this harder, but that does seem to have a protective nature to it.

DR. LOOP: The incentive to train more residents though is blunted by the cost factor which increases today, and also the Balanced Budget Act, and the RRCs.

DR. WILENSKY: By the cap.

DR. ROWE: The '96 cap. There is no incentive to train.

DR. LOOP: So I don't think the incentive to train more residents is a big factor today.

DR. WILENSKY: We do have this issue, there still is substantial variations. The Balanced Budget Act puts the limit on but doesn't take account of the fact that there still is not much incentive to go down at your at the cap or if you're anywhere below the cap. If we can find -- and this is one of the empirical issues that we'll have to wait to see what happens. If there's a way to provide a parameter other than number of residents with regard to the

best predictor of these increased costs, it would clearly be preferable.

MR. PETTENGILL: Or something in conjunction with it.

DR. WILENSKY: Right. But I think this is the kind of information that, as you're able to do some estimations, we'll be able to come back to in terms of how we would actually want to suggest distributing these monies.

DR. LOOP: If we're going to have a multifactorial search here, could you summarize the multiple factors we're going to investigate? The proxies have been listed here, but what are you really going to look at?

MR. PETTENGILL: I wouldn't pretend to try to give you a list without thinking about it a whole lot further.

DR. LOOP: All right.

DR. WILENSKY: Why don't you have a conversation sometime between now and our November meeting?

DR. NEWHOUSE: But by January the enhanced DRGs is what I heard.

MR. PETTENGILL: Oh, yes. All of the stuff that

was in the workplan is going to be -- it's in progress.

DR. ROWE: But just send us a list of what you think it might be, and things you're considering, or people's suggestions.

DR. LAVE: And we could send him a list of things that you might want him to consider as well, because there be something that's there.

MR. PETTENGILL: You have my e-mail address. I'm open to any and all suggestions.

DR. ROWE: Proportion of patients that arrive via the airport. That would be a good one.

MR. PETTENGILL: Actually, if we could just send somebody around with a GPS reader and get the locations of -- actually we probably could do this and do it quite well these days with mapping programs. But look at where the patients come from.

DR. WILENSKY: Where the patient pool --

MR. PETTENGILL: Now that may be a little bit misleading because you would get a different regional distribution just, say for the Mayo Clinic, than you might

get for an equally --

DR. KEMPER: And don't forget hospital systems.

MR. PETTENGILL: Yes, of course. There are problems with almost any measure you can imagine.

DR. WILENSKY: Thank you. Perhaps some useful suggestions will come from commissioners into you, but you may want to try to have a conversation offline with a couple of the commissioners who have indicated particular interest in this before we reconvene in November. Thank you.

This is the time for public comments, if there are people that would like to make a comment.

MS. FISHER: Karen Fisher with the Association of American Medical Colleges. Given the discussion today concerning the universe of entities you appear to be talking about, I think they're teaching facilities or entities. I think that the suggestion to think about another name change for the adjustment would be useful because there are people who are not part of these discussions and don't read the transcripts who see the term enhanced patient care adjustment and are not sure who you're talking about. So I

think that would be useful.

We would help to sponsor the contest for the renaming and help out if that would do any good.

[Laughter.]

MS. FISHER: But I think that would help clarify what I think I'm hearing people are saying.

DR. WILENSKY: Thank you. We might take you up on your offer.

MS. TAYLOR: My name is Pat Taylor. I'm an independent consultant specializing in rural health policy issues. I want to speak to your discussion of the DSH payment reform and particularly to the table that showed the percentage change in total payments going to groups of hospitals by teaching and non-teaching, and public and private. I was very interested in Dr. Wilensky's comment about how this seemed to be a real shift from private, including for-profits and non-profits, to public. I just thought, why will this be? A lot of the money shift would be going to rural hospitals.

I think Jack Ashby said that one reason is because

there are going to be a lot more -- you expanded the number of rural publicly-owned hospitals. I think that's probably a big expansion. Off the top of my head, I think that 40 percent of rural hospitals are publicly owned. That's a very high percentage. Often by -- usually be county governments. So that, expanding the number of hospitals certainly would change the -- or explain part of that.

But then the further question was, will these monies really be directed where there are Medicare patients, to benefit Medicare patients. Many rural hospitals have very high proportions of Medicare patients. It's not unusual for a rural hospital to have 60 percent or more of its inpatient days by for Medicare patients. So I think that's not a reason -- so I think you need to see more of the numbers and breakdowns before you see how this plays out.

DR. WILENSKY: Thank you. The numbers of rural hospitals that are public and the differentiation between urban and rural is a useful concept for us to think of.

MS. COLLINS: I'm Molly Collins with the American

Hospital Association. I just wanted to make two brief comments on the payment adequacy section and then follow up with Commission staff in a more detailed response. The first comment is really more of a note of caution and that is, hospital margins can turn negative quickly and we just have to look back and Medicare PPS experience. Margins between 1987 and 1992 declined rapidly after government-imposed payment reductions.

The second comment is regarding the Balanced Budget Act and its future effects. Ninety percent of the PPS cuts have yet to be felt by hospitals because the BBA '97 payment reductions were back-loaded. Thank you.

DR. WILENSKY: Thank you.

We will be meeting the week before Thanksgiving, November 18th and 19th. We are at Embassy Suites here again. Thank you.

[Whereupon, at 12:50 p.m., the meeting was adjourned.]